Women's Experiences of Unplanned and Emergency Caesarean Section within New Zealand's Maternity System

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Abstract

Background: In New Zealand, normal birth has been at the core of the maternity philosophy, particularly among midwives. The midwifery model provides continuity of care during pregnancy, childbirth, and up to six weeks postnatally - women who experience continuity of care report greater satisfaction with their maternity provider. Yet, caesarean section rates continue to rise globally, and the current rate in NZ is estimated at 25-30%. Unplanned and emergency caesarean section (CS) complicates a woman's care journey as care is transferred from a Lead Maternity Carer (LMC). A transfer of care to a hospital-based obstetric specialist may take place in what are often unanticipated and challenging circumstances. Women who undergo CS commonly report increased negative birth experiences, specifically, more extended maternal recovery periods, lower breastfeeding rates, and increased risk of post-traumatic stress disorder. The research sought to understand the participants' experiences and the nature of care for women during and after unplanned/emergency CS in Canterbury, New Zealand, adopting a post-structuralist feminist perspective.

Method: This qualitative study explored the experiences of 30 women who had undergone unplanned and emergency caesarean section and the accounts of 11 lead maternity carers' (LMCs). Data were collected using in-depth semi-structured interviews. The data were analysed using the Framework approach described by Ritchie and Spencer, and thematic-discourse analysis was used to identify and describe meaningful concepts in the data.

Findings: Analysis of the interviews with new mothers revealed an overarching theme - 'the mixed emotions of becoming a mother from an unplanned/emergency caesarean birth' - from which nine key themes emerged. Collectively, the themes highlight the conflicting feelings participants experienced in their connection to their lead maternity carer (LMC) but

disconnection to their experience of emergency caesarean section. Mixed emotional reactions from the caesarean delivery revealed that despite the relief of a live birth, the mothers experienced emotions that included a lingering sense of failure, disappointment, and loss of agency. These findings are linked to the incongruity of women's birth expectations and outcomes. Triangulation with findings from the interviews with the care providers identifies opportunities for health system strengthening.

Conclusion and implications for practice: Drawing on Foucault's discussion of knowledge and power to apply analyses of governmentality surrounding birth discourses within the context of a midwifery dominated health system. This thesis contributes an understanding that while the techniques of governmentality remain constant, the sense of individual responsibility that accompanies natural birth discourses elicited emotions of guilt and disappointment among women. The research makes visible the contested nature of the discourses of natural birth among women who experience operative deliveries, thereby highlighting the need for more nuanced antenatal education and wrap-around support post-CS.

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Dedication

In loving memory of Chief Matthias Odogu Abule.

Throughout your lifetime, you lived for others and showed limitless generosity and care to everyone who crossed your path. I hope that this achievement will make you proud like you always were of me.

Your memory will live on.

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Chapter One: Introduction

1.0. Background

Childbirth is considered among many social scientists to be a "socially constructed experience" as much as it is a physiological phenomenon (Sutherland & Bay, 1997, pg. 7). By its nature, childbirth is a transformative experience that creates new kinship networks and transmits values and experiences (Ivry, 2010; Rezende, 2011; Symonds, Hunt, Symonds, & Hunt, 1996). This view has informed the sociological argument that in exploring women's experiences of childbirth, approaches that rely mainly on medical and psychological models fail to locate the subjective meanings women attach to the act of birthing (Rothman, 1977). Consequently, many have argued that interpretations of the nuances of childbirth should focus on the views held by women rather than the dominant professional perceptions that impact the ways women conceptualise, define and construct their birth experience (Arslanian-Engoren, 2002).

Many factors, including her birth expectations, can influence a woman's birth experience, cultural beliefs, available social support, past traumatic life events, perceived sense of control, attributed meaning, and attitude towards childbirth (Carquillat, Boulvain, & Guittier, 2016; Nilsson, Lundgren, Karlström, & Hildingsson, 2012; Nilsson, Thorsell, Hertfelt Wahn, & Ekström, 2013; Redshaw & van den Akker, 2008). Birth expectations may be culturally or socially constructed, often in keeping with popular ideologies of wider society. Thus they are dynamic and sometimes fall between public and personal belief orientations (Ayers & Pickering, 2005). Documented expectations around childbirth relate to birth place, birth type, support from partners and families, baby's health and wellness, pain management during labour and, inclusive support from care providers such as doctors, nurses, midwives, and or

obstetricians (Moore, 2016). Even before women experience birth themselves, many of their views and perceptions are learned and transmitted through resources such as families (mothers), friends, birthing books, mainstream and social media, as well as academic literature (Cook & Loomis, 2012). In recent times, women's birth choices and their perceived sense of autonomy and control of the birth process play a key role in determining the positive or negative recollections of their birthing experiences (Cook & Loomis, 2012).

While childbirth remains a uniquely life-changing, multi-faceted event for most women and their families (Afaya et al., 2020), labour and delivery experience can have an emotional, psychological and physical impact on their health and well-being (Kashanian, Javadi, & Haghighi, 2010). In an emergency obstetric situation (such as, obstructed labour, fetal distress, breech presentation, antepartum haemorrhage, hypertensive disorders and diabetes), where the wellbeing of a woman or her baby is at risk, unplanned or emergency caesarean section (CS) may be undertaken. Women who undergo an unplanned caesarean section have reported increased negative birth experiences, specifically, longer maternal recovery periods, lower rates of breastfeeding, initial maternal bonding difficulties, and increased risk of postpartum post-traumatic stress disorder (Guittier, Cedraschi, Jamei, Boulvain, & Guillemin, 2014; Ko, Lin, & Chen, 2015; Ryding, Wijma, & Wijma, 1997; Somera, Feeley, & Ciofani, 2010; Wijma, Ryding, & Wijma, 2002; Fenwick, Gamble, & Mawson, 2003; Handelzalts et al., 2017). Studies show that a negative birth experience impacts the woman's health, her newborn and may impact family dynamics (Mutryn, 1993; Rowe-Murray & Fisher, 2002). Unlike an emergency or unplanned delivery, planned birth (vaginal birth or elective caesarean) is associated with greater positive outcomes or experiences, as the woman exerts her autonomy and choice, as well as increased involvement in decision-making around her birthing (Handelzalts et al., 2017; Hodnett, 2002; Spaich et al., 2013). A positive birth

experience can promote self-confidence, fulfilment and increased self-esteem (Callister, 2005). Whereas negative or traumatic birth can result in regret, dis-empowerment and a sense of failure (Ayers, Bond, Bertullies, & Wijma, 2016; Gottvall & Waldenström, 2002; Handelzalts et al., 2015, 2017). Jordan and Davis-Floyd (1993, pg. 48) claimed that ‘‘a society’s way of conceptualising birth constitutes the single most powerful indicator of the general shape of its birthing system’’. In New Zealand, childbirth is popularly conceived as a physiological, natural phenomenon rather than a medical and technological process. Promoting normal birth has been at the core of the maternity philosophy, particularly among midwives who make up close to 90% of maternity care providers (New Zealand College of Midwives, 2009). Despite the use of terminologies such as ‘abnormality’ to connote operative deliveries or the use of high-tech obstetric interventions in childbirth, records show that instrumental deliveries and caesarean section rates are on the rise in NZ (McAra-Couper & Hunter, 2010; Ministry of Health, 2017).

1.1. Rationale

In New Zealand, normal birth has been at the core of the maternity philosophy, particularly among midwives. New Zealand’s maternity system is dominated by midwives and represents a departure from the recent tradition of medicalised birth. Midwives are the lead maternity carer at 94.2% of births in New Zealand (Ministry of Health, 2017). The midwifery model provides continuity of care during pregnancy, birth, and six weeks postnatally (McAra-Couper et al., 2014). Women who experience continuity of care report greater satisfaction with their maternity provider (Perriman, Davis, & Ferguson, 2018). However, unplanned/emergency caesarean section potentially complicates a woman’s care journey as

the midwife transfers care to a hospital-based obstetric specialist in what is often unanticipated and challenging circumstances (Grigg, Tracy, Schmied, Monk, & Tracy, 2015). While CS is safer now than in the past, research suggests that women who undergo a caesarean birth commonly report increased negative birth experiences. For example, more extended maternal recovery periods, lower breastfeeding rates, and increased risk of post-traumatic stress disorder (Australian Institute of Health and Welfare, 2013; De-Souza et al., 2015; Kabakian-Khasholian, 2013).

One key question researchers and policymakers have constantly asked regarding caesarean section is "why the global rise in prevalence?" As I pondered on this typical public health question and started to develop my investigation to find answers, I realised that there is a lot more that would feed into our understanding of that question. Hence, my particular focus on women's expectations and experiences and the relationship with some of the discourses that prevail in care.

As I began to think about the sense of responsibility both on women and their primary care providers in childbirth preparation and the nuances of normality within the current model of care, I wondered about a link between birth expectations and the incongruence of experience for the women who experienced an unplanned/emergency CS. Therefore, this research aimed to understand better women's lived experiences of an unplanned/emergency CS and the perspectives of lead maternity carers to identify whether the maternity system meets these women's care and support needs.

To date, in New Zealand, few studies have attempted to explore women's experiences of an unplanned/emergency caesarean section, alongside the perspectives of lead maternity carers.

This study responds to the need for optimisation in maternity research that provides context-rich information to support the optimal care for women and babies (Ministry of Health, 2011). In line with the Ministry of Health Report on Maternity Quality and Safety Programme (Ministry of Health, 2015a), this thesis seeks to improve health care quality for childbearing women and their infants by contributing to research that strengthens health service.

1.2. Research question

The study seeks to answer the following research questions by exploring women's lived experiences and perceptions around birth and that of health providers' on maternity care after unplanned and emergency caesarean section.

1. What are women's birth expectations, and how do these compare with their experience of an unplanned and emergency caesarean section ?
2. How do women's experience of unplanned/emergency caesarean section impact their physical and emotional well-being and their transitioning to motherhood?
3. What are midwife and obstetrician LMC's perceptions of intrapartum and postpartum care and support for women who have unplanned and emergency CS within the NZ maternity system?

I generated the research questions from my interest to understand how women experience unplanned/emergency caesarean sections within the context of the New Zealand maternity system. It is also a reflection of the examination of previous research on the topic within different contexts.

1.3. Objectives

The research questions, all akin to gaining an in-depth understanding of women's caesarean birth experiences in the context of the maternity system, formed the basis of the thesis. With this in mind, the research objectives are:

- To explore women's expectations of birth and their experiences of an unplanned and emergency caesarean section.
- To understand women's view of the impact of their experience on their well-being.
- To describe lead maternity carers' accounts of the nature of care for women during and after unplanned and emergency caesarean section
- To examine how New Zealand's maternity system affects women's experiences of unplanned/emergency CS.

1.4. Study Context

Canterbury is one of the largest district health boards (DHB) by population and geographical area of all DHBs in NZ. With a population size of about 614,628, it accounts for about 12% of the total NZ population (Environment Canterbury, 2019; StatsNZ, 2019). Around 18 babies are born daily in Canterbury, with close to 6500 live births annually (CDHB, 2019b). The number of women giving birth at the region's only tertiary maternity facility, Christchurch Women's Hospital (CWH), has steadily increased over the last decade. However, records show a slight decrease in 2017 and 2018 compared to other years (See table Two). Almost 81% of births in the region occur at CWH, with just under 14% in

Primary Units and only about 5% are home births (CDHB, 2019b). On an annual basis, close to 7000 specialist obstetric consultations occur at CWH, which also receives all referrals for tertiary level care in the region (Canterbury DHB & West Coast DHB, 2013, 2016; CDHB, 2019b, 2019a).

CDHB Maternity Facility	Number of Births				
	2014	2015	2016	2017	2018
Christchurch Women's Hospital	5165	5220	5259	5229	5024
Ashburton Maternity (p)	117	134	144	134	123
Burwood Birthing Unit (Closed June 2016) (p)	147	185	54	-	-
Darfield Hospital (p)	6	5	4	2	1
Kaikoura Health Hub (p)	11	9	13	16	9
Lincoln Maternity Hospital (p)	107	129	140	170	167
Rangiora Health Hub	125	178	215	238	212
St George's Maternity (from Feb 2014)	141 (Feb-Dec 2014)	214	255	323	457

Homebirths[1]	262	280	334	345	380
Grand Total	6055	6256	6418	6457	**6373**

Table 1: Registered 'Live births' in Canterbury 2014-2018 by location (CDHB, 2019b)

(p) = primary unit

Available data show a decrease in spontaneous vaginal birth (64.5%) of almost 4% since 2016 in Canterbury, which is slightly lower than the national average of 65.1%. The instrumental vaginal birth (IVB) rate has also fluctuated since 2009. While records show a decrease in IVB between 2009 and 2014, current data suggest an upward trend since 2016. Data gathered from an official information act request (appendix IV) revealed that in 2018, out of the 6373 live births recorded in Canterbury, 1830 (28.7%) were by caesarean section, with about 48% of those being unplanned (CDHB, 2019a). Table two below shows the number of caesarean sections (planned and unplanned) performed in Canterbury in 2018.

	Number
Emergency classical caesarean section	10
Emergency lower segment caesarean section	867
Elective/planned caesarean section	953
Total caesarean section performed	1830

Table 2: Unplanned CS in Canterbury 2018 (CDHB, 2019b)

[1] According to CDHB:

> Canterbury's home birth rates have historically been difficult to capture. Prior to May 2017, home births were captured via the National Immunisation Register (NIR) meaning births where a parent opted their child out of the NIR were not included. From 1 May 2017 onwards homebirths in Canterbury were captured more accurately through the LinKids programme. (2019, pg. 2)

Emergency caesareans are publicly funded in New Zealand, and are usually carried out by a multidisciplinary care team comprising an obstetric registrar and house surgeon, anaesthetist, anaesthetic technician, nurse, hospital midwife, Neonatal consultant, and other members of the clinical team (Canterbury District Health Board, 2019).

In Canterbury, primary maternity care is provided by a publicly-funded community-based lead maternity carer (LMC) system similar to other regions in NZ. The LMC is responsible for the care of women through pregnancy, beginning with a first appointment at approximately 10-14 weeks through to six weeks postnatally (CDHB, 2018). Roughly 80% of expectant mothers in Canterbury register with a lead maternity carer (LMC) in the first trimester of their pregnancy, with about 94% of women with a midwife LMC (CDHB Maternity Quality and Safety Programme 2019 Report; Ministry of Health, 2017). Between December 2010 and December 2017, records show a notable decrease of 4.3% (headcount) and 2.6% (full-time equivalent) in the national midwifery workforce (excluding LMCs) across the entire 20 DHBs (Pather, 2018). 318 LMC midwives practice in Canterbury. About 229 (10.5% of the national workforce) have an access agreement with maternity facilities and, therefore, provide LMC services that include attending institutional births (CDHB, 2019b). Broadly, the maternity services in the region are provided across three divisions/regions: Women's and Children's Health (Christchurch Women's Hospital, St. George's Maternity Centre, Rangiora Health Hub, and Lincoln Maternity Hospital), Ashburton Maternity Centre, and Rural Health Services (Kaikoura, Darfield, including cover services for the Chatham Islands). The LMC remains the primary carer during labour unless care is transferred. It is important to note that core DHB midwives are also on call as a

backup in these facilities. CDHB also has a shared governance relationship with the West Coast DHB, and it provides several health services to the West Coast population.

Canterbury DHB is not uniquely different from other regions. It aligns with the NZ maternity standards, which expect that high-quality, publicly-funded, consistent, and women-centred maternity services (Canterbury DHB & West Coast DHB, 2013). Some of the current challenges and pressures facing Canterbury are common across the maternity system. For example, increased waiting times and workforce shortages (Ministry of Health, 2017). Therefore, any maternity system-focused research conducted in New Zealand has the potential to have wide-reaching implications with the potential to improve women's birth experiences. Studying the experiences of women living in Canterbury of an unplanned CS provides an opportunity to better understand the broader New Zealand context.

1.5. Outline of thesis

Chapter one has presented a brief background to the study, highlighting the rationale, research questions, objectives, and thesis outline. This chapter also addresses the health system context in the study region. Chapters two and three both present a review of relevant literature.

First, chapter two reviews the literature on the evolution of CS from a global and NZ perspective, highlighting the role of risk perception in the increasing use of interventions in childbirth. Further, the implication of CS on maternal and neonatal well-being is explored. Second, chapter three discusses the literature on the history of maternity care in New Zealand from midwifery and feminist perspective. It begins with exploring the literature on feminist

poststructuralism to review some of the historical and professional issues on women's experience, childbirth philosophies, and maternity care.

Chapter four discusses the methodological framework of the research. The ontology (relativism) and epistemology (subjectivism and constructionism) are discussed as philosophical orientations that inform the researcher's theoretical grounding. Feminist poststructuralism is presented as the ideological basis/grounding that reflects the nature of the inquiry and informs the study design. Further, the research method, contextual details on data collection (in-depth interviews), discussions on ethical considerations, and data analysis are presented.

The research findings are presented in two chapters (five and six). Chapter five outlines the interviews with lead maternity carers as they describe the nature of care for women during and after unplanned and emergency caesarean section. Chapter six lay out the findings from the interviews with maternity users. A discussion of the implications of the findings with recommendations is presented in chapter seven, followed by the conclusions in chapter eight.

Summary

In this chapter, a brief discussion of the background of the study, the objectives, research question, the rational and potential significance of the research were presented. The research offers an opportunity to explore the experiences of women in Canterbury, New Zealand, who have unplanned CS, alongside the perspectives of lead maternity carers. The goal is to gain insight into women's lived experiences of CS and identify whether the maternity system in New Zealand meets these women's care and support needs. In addition, the study's findings may provide valuable insight on how the maternity system can reconceptualise support for women after unplanned CS.

Literature review

Introduction

The review of the literature is presented in the following two chapters. Both chapters (two and three) provide an expanded background to the study by examining the available evidence on women's experiences of unplanned/emergency CS.

The section begins with an outline of the review process. Chapter two presents a synthesis of the literature on caesarean section and unplanned and emergency caesarean birth. The chapter begins by discussing the social construction of CS, drawing from a feminist lens. Then, the chapter sheds light on the historical and current outlook of CS from a global perspective and discusses the evidence from New Zealand's viewpoint in comparative terms. It further examines critical literature on the determinants and implications of CS rates and notes key aspects of the studies that build on the relevance of current research.

A review of the literature on midwifery and the historical outlook of childbirth in New Zealand from a feminist viewpoint is presented in chapter three.

Studies such as the current research, which seeks to engage women's view of their lived experiences around childbirth, often adopt a feminist approach as the theoretical guide, emphasising gender relations and social change. Therefore, in chapter three, the feminist perspective is introduced, and a historical view of childbirth in New Zealand discussed through a poststructuralist lens. The intention was not to exhaustively review the academic literature on midwifery and birth but to explore the historical changes and practices of maternity care delivery in New Zealand. Specific attention is paid to childbirth within the Māori context, highlighting early birthing practices, midwife-led care and the evolution and

professional tension in the maternity system while drawing from the history of medicalisation and hospitalisation of birth. A discussion of the current two-tier system of maternity services within the current lead maternity carer model in New Zealand is further elaborated.

There is no consensus on whether to conduct a literature review at the onset of qualitative research. Grounded theorists encourage researchers to adopt reflexivity, focus on the data, and avoids any bias or preconception generated by the literature review to distort the data analysis and interpretation (Dunne, 2011; McGhee, Marland, & Atkinson, 2007; Ramalho, Adams, Huggard, & Hoare, 2015). However, this approach can be complex for emerging researchers unfamiliar with the methodology and the research topic. Thus, conducting the literature after data collection and analysis can be problematic (McGhee et al., 2007).

Most researchers carry out a literature review earlier to understand how the research fits into the field of inquiry (Merriam & Tisdell, 2015). Also, to draw inference from similar studies to identify gaps and justify the methodological approach, theoretical and conceptual framework for the current research (Boote & Beile, 2005; Merriam & Tisdell, 2015; Randolph, 2009). This research has taken this approach.

A search of relevant literature was conducted between September 2017 and December 2018 using different electronic databases, including PubMed, MEDLINE, CINAHL, The Cochrane Library, ScienceDirect, Google Scholar, and Scopus. The search terms and word combinations used include “women”, “experience”, and “caesarean section”. I added specific words and phrases to narrow the search, including “perceptions”, attitudes”, “caesarean birth”, and “maternity system” “New Zealand”. Search results were extensive and of both qualitative and quantitative studies. I read abstracts to identify papers of interest. In addition, I checked the reference lists of selected articles to broaden the literature search. As I

progressed with the thesis, I added additional literature to the review from repeated searches in 2019 and 2020, thus, expanding the list of the literature examined.

Chapter Two: Perception of Risk and Caesarean Section

2.0. Introduction

This chapter presents an exploration and critique of the literature about caesarean section, highlighting how risk perception plays a key role in maternity services and the increasing rate of interventions in pregnancy and childbirth. The historical and contemporary outlook of CS is discussed, addressing both global and NZ perspectives and rates. Further, the implication of CS on maternal and neonatal well-being is explored.

Globally, women have become subject to rising rates of interventions in childbirth, which is predicated upon the reduction of intrapartum and postpartum risk for the woman and or her child. Social scientists, midwives, and clinicians have varied markedly in their representations of the nature of risk in childbirth and the social-cultural context within which risk is conceptualised. However, remarkable consistency among social theorists is that risk has become increasingly inescapable, creating anxiety and uncertainty even within the social space of technological and scientific advancements (Giddens, 1990; Lash, Szerszynski, & Wynne, 1996; Mitchell & McClean, 2014; Watson & Moran, 2005).

Some have attempted theorising risk as a techno-rational and sociocultural concept (Douglas, 1992; Lupton, 2013; Mythen, 2004; Skinner & Maude, 2015; Zinn, 2008). Techno-rational risk theory focuses on determining risk by mathematical probability of occurrence, which creates a dichotomy between what is normal, measurable, and controllable and what is considered uncontrollable, unmeasurable, and abnormal (Hacking, 1990; Skinner & Maude, 2015). However, sociocultural theories of risk support the view that health care providers and childbearing women do not perceive risk in the same way, which accounts for the differences observed in the care of patients (Page & Mander, 2014). Research suggests that the trigger for

risk is ‘uncertainty, and its perception is determined by how the woman and her healthcare provider cope with that uncertainty (Lankshear, Ettorre, & Mason, 2005; Page & Mander, 2014; Skinner & Maude, 2015). But since uncertainty refers to a “prediction where there is a lack of empirical evidence” (Page & Mander 2014, pg. 29), it becomes challenging to determine alternative outcomes mainly based on mathematical probability.

Though the management of risk in pregnancy and childbirth seeks to improve patient safety and the quality of care, it has also contributed to the “intensification of risk discourse” in maternity services (Healy et al., 2017, pg. 2). It may create an atmosphere where fear and concern for safety influence clinical decision-making and contributes to the rise in routine use of technological interventions in pregnancy and childbirth (Crawford, 2004; Healy et al., 2017; Page & Mander, 2014). The safety concern has created what Beck described as the “risk society” that permeates maternity systems in many developed countries and intensifies clinical governance in maternity care (Beck & Ritter, 1992). According to Healy, clinical governance contributes to increased dominance of the medical model and has threatened midwife-led care and normal birth philosophy (Healy et al., 2017). The need for a paradigm shift from focusing on risk in the planning of women’s maternity care to a focus on women’s health and wellbeing is, therefore, pertinent. This may provide an alternative to the risk culture that contributes to increasing interventions in childbirth and may improve outcomes for childbearing women (Healy et al., 2017).

2.1. Caesarean section as a medical intervention

Caesarean section[2] (CS) entails the delivery of a foetus through surgery (incision in the abdominal and uterine wall) (Rousset & Baskett, 2010). CS is carried out in an obstetric-risk situation (for example, placental abruption, foetal distress, uterine rupture, or cord prolapse), when a vaginal birth becomes unsafe (emergency). Though, in some cases chosen by the patient in the absence of any known medical condition (elective) (Dickinson, 2014; Douché & Carryer, 2011; McAra-Couper, Jones, & Smythe, 2012; National-Institute-for-Health-and-Care-Excellence, 2011; Taylor-Miller & Leanne, 1994).

Different accounts of the history of CS exist. Historically, Julius Caesar's was believed to be the first to be born via CS (Todman, 2007). However, considering that the procedure was only performed on a dying or dead mother during this time, many have discounted this view since caesar's mother outlived his birth (Churchill, 1997; Todman, 2007; Low, 2009; National-Institute-for-Health-and-Care-Excellence, 2011).

Blumenfeld-Kosinski (1990) provides a historical backdrop of the early traditions of caesarean operations. In her text, she traces the evolution of caesarean delivery through articulated comparisons of images and texts as perceived by medical practitioners, pregnant women, and literary and artistic historians. Blumenfeld-Kosinski adds valuable knowledge to pre-modern caesarean births and provides new perspectives on understanding pregnancy and childbirth practices in the middle ages. Also, Churchill (1997) presented a comprehensive socio-political map of the rise of CS to the present day. Her work incorporates an extensive historical study into women's experience of caesarean delivery. The works of Blumenfeld-

[2] also referred to as caesarean operation, caesarean birth or caesarean delivery, CS

Kosinski and Churchill demonstrate both a cultural, medical, religious, and socio-political history of caesarean section and informs the following paragraphs to highlights the place of the operation in the historical construction of gender roles.

Caesarean is from the Latin word *caesaru,* which translate to the English word ‘to cut’. The word section also originates from the Latin phrase *seco,* which also translate literally to the English words ‘cutting’ or ‘to divide’ or ‘to part’, therefore, suggesting a plausible interpretation of the term caesarean section to mean ‘to cut open’ (Churchill, 1997). According to Blumenfeld-Kosinski (1990), the first reference to a caesarean birth dates back to 715 BC in the Roman King Numa Pompilius. The proclamation of the *Lex Regia*, later known as *Lex Caesarea* (Gupta, 2008), made it unlawful for women who die during childbirth to be buried along with their unborn infants. Initially, this was to comply with religious customs and roman rituals that forbade pregnant women's burial (Churchill, 1997; Gupta, 2008). Thus, the unborn child must be cut out from the uterus of the woman, giving credence to the belief that a caesarean section was performed post-mortem to save the unborn child's life and perhaps explain the origin of the unborn child term ‘caesarean’ (Churchill, 1997).

Testimonies of the *lex regia* were transmitted through centuries and appeared in the writings of early Middle Ages of Egyptian, Indian, Jewish, Grecian, and Roman scholars (Blumenfeld-Kosinski, 1990; Gupta, 2008; Todman, 2007). For example, Maimonides (1135-1204), a physician and writer of medical literature, claimed that knowledge of how to ensure the mother's safety during a caesarean birth was common in Rome in the ancient and medieval times. However, such practice was not often followed (Todman, 2007). Maimonides also suggested that the incision during the caesarean birth be done on the woman’s side rather than the typical frontal lower abdominal incision (Blumenfeld-Kosinski,

1990). However, it is unclear whether this assures the mother's survival and safety. Also, records suggest that removing a live unborn infant from their dead mothers was a compulsory act among ancient Indian Hindus in 1500 BC and early Egyptians of 3000BC (Churchill, 1997). Furthermore, Catalan saint Raymond Nonnatus in 1204, Robert II of Scotland in 1316, and the depiction of the Shakespearean character Macbeth were all believed to have been born through a caesarean delivery. Notably, in all of these mentioned, none of the mothers survived (Todman, 2007).

Religion played a vital role in decision-making around many life events during the pre-industrial times, including childbirth (Churchill, 1997). Before 1500, caesarean operation was anathema to Islamic beliefs. Children born by caesarean operation were regarded as the 'devil's offspring' and immediately killed (Gupta, 2008). The mid-1500s abolished the practice. Conversely, Christianity accepted the procedure to save the unborn child's soul and give them the opportunity for baptism. The child's survival was of utmost importance, with little regard paid to the mother's life. In particular, the Catholic Church promoted the practice and often trained priests on relevant maternal anatomy and caesarean operation to enable them to carry out CS in a dying pregnant woman (Gupta, 2008). The church, which staunchly opposed abortion practices, frowned at any attempt to save a pregnant woman at the expense of the child through this means (Clarke, 2012). By 1280, caesarean operation was declared mandatory by the councils of the Catholic Church in Cologne, with strict penalties laid down on practitioners who failed to carry out the operation to save the life of an unborn child (Clarke, 2012; Gupta, 2008).

High rates of maternal death from caesarean sections led to debates over whether or not it was ethical to perform a caesarean section on living women. Many practitioners of the 16th century had completed and observed several caesarean operations on pregnant women

without the women surviving (Churchill, 1997). While some schools of thought believed that the procedure could help save women's lives in obstetric risk situations, others thought that the high death rates for mothers gave little or no justification for caesarean operation carried out on living women (Rosenberg & Trevathan, 2018).

By the 1500s, claims of mothers surviving caesarean operations were recorded, and by the 1800s, more records of survival of both the mother and the newborn were common (Moore & De-Costa, 2003). The first published record of a successful caesarean birth was published in the obstetric text *Hysterotomotokie* in 1581. Both the mother and infant survived. Jacob Nufer operated on his wife after remaining in labour for many days (Moore & De Costa, 2003; U.S. National Library of Medicine, 2011). Nufer's wife went on to have five other successful deliveries of 6 children, including a set of twins, which signalled the possibilities for caesarean operations with the survival of both mother and infant.

Another record of a successful mother and infant survival after caesarean operation was recorded in 1610, in Wittenberg, Germany, though the woman died of infection-associated complications several days later (Moore & De Costa, 2003). In 1738, in Dublin, Ireland, a midwife by the name of Mary Donnally, who was known for her expertise in removing deceased infants from their mothers, performed a caesarean operation on Alice O'Neale and assisted her to deliver her newborn, with both mother and child alive (Churchill, 1997; Moore & De Costa, 2003; Todman, 2007).

Notably, the record of Mary Donnally's successful operation was suppressed and concealed from history consistent with the dominance of male-midwifery during this period, which disregarded women's knowledge and excluded accounts from 'unqualified' witnesses (Cone, 1974; Ehrenreich & English, 1975; Radcliffe, 1989).

In 1604, Scipione Mercurio (Norman, 1991) published his thesis, which streamlined the procedure for a caesarean operation and advocated using sutures to hold together the abdominal wounds from the surgical incisions (Norman, 1991). It also raised cognisance of any medical conditions the women experienced before labour impacted birth experiences (Churchill, 1997). Mercurio's work was pivotal in the history of medicine gaining credit as the first text to advocate carrying out a caesarean section on living women.

The invention of anaesthesia with further medical advancements in the early-nineteenth century ushered in a new era for caesarean deliveries and obstetric science (Churchill, 1997; Todman, 2007). For example, in 1882, Max Sanger, a German surgeon noted to have performed 16 caesarean operations where 15 of the women and their babies survived the delivery (Gupta, 2008). Stories of this phenomenal achievement spread rapidly across Europe and the US. It was a remarkable shift from the periods of primary surgical operations like caesarean section done by laymen without anaesthesia. Furthermore, medical advancements in the infection control area helped reduce mortality rates and precision in caesarean operations (Todman, 2007).

By the mid-nineteenth century, the increased involvement of doctors in childbirth, advancements in operative deliveries, as well as a surge in publications on obstetrics heightened the argument for the use of caesarean operations (Churchill, 1997; Gupta, 2008). This was crucial in helping to inform, empower, and prepare women for possible future operative deliveries and opened up an avenue for further discussions on the social implications of a life-saving caesarean birth. Further, it gave rise to the development of a caesarean birth method in the early 1970s, designed to enhance the childbirth experience of caesarean birth consumers through education and preparation for possible caesarean delivery during labour (Donovan & Allen, 1977).

With the increased incidence of caesarean deliveries, professional concern for women's psychological well-being who undergo a caesarean birth and implications for families became heightened. This led to the pioneering of a comprehensive approach that enhanced the caesarean birth experience for women and their families (Donovan & Allen, 1977). The flipside being the increased medicalisation of birth, seen as a means of taking delivery away from the traditional female-dominated into a male-dominated obstetric field, making medical interventions in natural childbirth almost routine, even when not medically necessary (Brubaker & Dillaway, 2009; Cahill, 2001; Jennifer Fenwick, Staff, Gamble, Creedy, & Bayes, 2010; Johanson, Newburn, & Macfarlane, 2002; Peel, Bhartia, Spicer, & Gautham, 2018; Penna & Arulkumaran, 2003).

2.2. Caesarean section in New Zealand: A comparative perspective

Historically, CS in New Zealand was an uncommon, destructive, and dangerous operation, and the practice remained contentious until the mid-19th century (Clarke, 2012). The first acclaimed caesarean delivery was performed on Jane Filmer in Onehunga, Auckland, in 1857 by Surgeon Henry Weekes alongside three other doctors. Though the operation delivered a healthy child, the mother eventually died during the process, which was an expected outcome in caesarean delivery during this period. In 1890, Doctor William Stenhouse carried out the first record of a successful caesarean operation, with mother and child alive, on Mary Leslie, who had been in labour for several days. Before this time, caesarean section remained a risky medical operation associated with high maternal mortality, with close to 85% of maternal deaths linked to the procedure (Clarke, 2012). By 1891, the rate of maternal deaths from caesarean operations had reduced to between 10-25%. This dramatic reduction in New

Zealand's CS-associated maternal deaths was similar to other regions (such as Europe and America), where records of advancements in obstetric procedures, better control of post-operative infections, and the development of anaesthetics were common (Clarke, 2012).

By the early 20th century, caesarean births were on the rise even though there was very little information on the aetiology and critical accounts of caesarean operations, both from experiential understandings and clinical/non-clinical interpretations (Donovan & Allen, 1977; Douche, 2007; Low, 2009; Szabó, 2012). By 1971, the rate of caesarean section in the country was around 4%, which fell within the international standard range of between 3-5% (Douché & Carryer, 2011; Douche, 2007). By 1980, however, the caesarean delivery rate in New Zealand had doubled to almost 10% (Harris, Robson, Curtis, Purdie, & Cormack, 2007).

The World Health Organisation has warned that caesarean section raises the risk of postnatal death by 3.6 times compared to vaginal delivery. At the same time, the limit recommended by the WHO for the proportion of caesarean section deliveries relative to other forms of deliveries is 15% (WHO, 1994), [recent studies have suggested an optimal caesarean section delivery rate of 19% (Molina et al., 2015)]. CS rates in many countries remain above 15%, and in New Zealand, rates have been on a steady increase over the years; 11.7% in 1988, 20.8% in 2000, 23.1% in 2003, 24.3% in 2011, 25.3% in 2012 and 27.9% in 2017 (Ministry of Health, 2011, 2012, 2015b, 2017). In New Zealand, one in four women gives birth via CS. Of this number, more than half are unplanned or undertaken as 'emergency' operative procedures (Ministry of Health, 2017). In 2017, out of 58,260 births in New Zealand, 14,859 (27.9%)[3] were by caesarean operation. Of all caesarean births, 15.2% were emergency or

[3] An official information act request to the Ministry of Health shows that this is the most recent information held by the Ministry, the updated Maternity data will be published on the Ministry's website in 2020. See appendix 1.

unplanned (Ministry of Health, 2017 Maternity Reports). Furthermore, in Canterbury, the CS rate is estimated to be 28.7%[4]. Out of 6373 registered 'live births' in the region in 2018, 1830 were caesarean sections (953 elective/planned CS and 877 unplanned or emergency) (Canterbury District Health Board CDHB Official Information Request, 2019a).

The rates in NZ vary according to age, ethnicity, and geographical location. Across ethnic groups, age groups, and neighbourhood deprivation, the percentage of women who have had an emergency caesarean ranges from 11.4% to 22% in 2014 (Ministry of Health, 2014), and 12.0% and 25.2% by 2017 (Ministry of Health, 2017). Furthermore, rates of caesarean operation were higher among women 35 years and above, with the highest rates among women over the age of 40; suggesting an association between a woman's age and the likelihood of a caesarean birth (Korb et al., 2019; Ministry of Health, 2017; Rydahl, Declercq, Juhl, & Maimburg, 2019). Additionally, there is a pattern of distribution observed across different ethnic groups in New Zealand. The highest rates of CS is among women of Indian heritage (38.7%), followed by women of Asian background (32.9%) and women of European and other ethnic nationalities (29.2%) (Ministry of Health, 2017). Emergency or unplanned caesarean delivery was more common among women having their first childbirth, with rates of around 24.2%, compared to women who have had a previous birth (8.4%). In contrast, for elective caesarean, first-time mothers have about 6.6%, while women with at least two prior births have a rate of almost 16.7% (Ministry of Health, 2017). This elevated rate can be, at least partly, explained by women opting for the scheduled caesarean section due to the risks involved in the vaginal birth after caesarean (VBAC). In New Zealand,

[4] An official information act request to CDHB the Ministry of Health shows that this is the most recent information for Canterbury. See appendix 2.

women can choose an elective caesarean section for subsequent deliveries after an initial caesarean birth (Hill-Karbowski, 2014).

In geographical terms, the proportion of unplanned or emergency caesarean section in New Zealand was highest in the Wairarapa region, with a rate of 17.5% and lowest within the middle of the North Island with 9.6% recorded in the Whanganui region in 2014 (Ministry of Health, 2015b). Between 2013 and 2017, a significant increase in the rate of emergency CS in Hutt Valley DHB (14.1 – 20.4%), Auckland (15.4 – 19.2%), Waitemata (16.0 - 18.0%), Counties Manukau (14.9 – 18.1%) and Waikato (10.0 – 11.7%) (Ministry of Health, 2014, 2015b, 2017). However, Canterbury recorded a decline in emergency caesarean rate within this period, with rates dropping from 15.6 to 13.3% (Ministry of Health, 2017). Currently, 47.9% of all caesarean section in Canterbury is by emergency (CDHB, 2019a). In a clear north/south divide, elective caesarean birth was higher among women living in the South Island (14.2%) than those in the North Island (12.2%) in 2017. Auckland DHB region had the highest elective caesarean section rate of 15.6%, while Canterbury DHB recorded 15.1% for the period under review (Ministry of Health, 2017). The reason for this trend is unclear and perhaps suggests further studies in this area to provide a better understanding.

Compared to vaginal delivery, caesarean section is associated with a higher risk of maternal morbidity and mortality (Josefsson, Gunnervik, Sydsjo, & Sydsjo, 2011; O'Leary et al., 2007). Risk factors, including non-reassuring foetal testing, advanced maternal age, obesity, teenage pregnancy, abnormal foetal heart tracing, high birth weight, and gestational age are among the recorded risk factors for increasing CS in different countries (Bayrampour & Heaman, 2010; Gomes, Silva, Bettiol, & Barbieri, 1999; Gravett et al., 2016; Parissenti et al., 2017; Santos et al., 2014; Tang, Wu, Liu, Lin, & Hsu, 2006). In addition, obesity increased

the risk of a CS due to the likelihood of gestational diabetes resulting in pregnancy and labour complications (Gorgal et al., 2012).

Cellular and physiological changes that are associated with maternal age are linked to labour dysfunctions. According to Patel, women above 35 are more at risk of pregnancy and birth complications (Patel et al., 2017). Age is also associated with fertility complications (Noord-Zaadstra et al., 1991), genetic risks (Campbell, Furlotte, Eriksson, Hinds, & Auton, 2015), miscarriage (Andersen, Wohlfahrt, Christens, Olsen, & Melbye, 2000), foetal abnormalities (Jolly, Sebire, Harris, Robinson, & Regan, 2000), stillbirth (Huang, Sauve, Birkett, Fergusson, & van Walraven, 2008; Reddy, Ko, & Willinger, 2006), maternal morbidity (Ban et al., 2017; Blencowe et al., 2016; van-Alebeek et al., 2018; Wang et al., 2011) as well as postnatal complications (Jolly et al., 2000; Kaimal, Newman, Croft, & Ecker, 2012; O'Leary et al., 2007; Yoshioka-Maeda, Ota, Ganchimeg, Kuroda, & Mori, 2016) increase the chances of surgical interventions in childbirth.

The WHO (2010) report on the determinants of caesarean section rates in developed countries revealed that around 54 countries have a caesarean rate lower than 10%, with 69 countries reporting rates above 15% (Gibbons et al., 2010). Fifty countries record caesarean section rates of more than 27% (Molina et al., 2015), with economic determinants and maternal mortality associated with this difference (Gould, Davey, & Stafford, 1989; Lauer, Betrán, Merialdi, & Wojdyla, 2010; Ronsmans, Holtz, & Stanton, 2006). The socio-economic links with global caesarean section rates have prompted many questions and concerns over the justification of caesarean operations. The global rise in CS rates is connected with concerns about the impact on women's pregnancy outcomes, post-operative psychological wellness, and the newborn and the family dynamics. In addition, the associated high cost of the increasing caesarean rate on health systems raises policy and economic concerns (Betran,

Torloni, Zhang, & Gülmezoglu, 2016; Betran et al., 2015; Bryant, Porter, Tracy, & Sullivan, 2007). According to Ronsmans et al. (2006), socio-economic differentials, economic status, health insurance, and country of residence are notable and associated with consumption and use of caesarean operations globally. Cross-sectional data analysis from 38 countries, including New Zealand, Australia, the United States of America, Canada, and Japan, have shown that a doubling in per capita income correlates to a 33% increase in the rate of caesarean delivery in high-income countries (Gibbons et al., 2010; Lauer et al., 2010). Thus, suggesting a positive association between the health system's capacity to deliver surgical, obstetric care and the rate of caesarean births.

The WHO report on determinants of CS rates in developed countries shows that a doubling in the number of hospitals and hospital beds per head corresponded to a 15% and 26.8% increase in caesarean deliveries, respectively, in the short term (Lauer et al., 2010). In contrast, a doubling in the number of midwives per individual resulted in a 3% increase in caesarean delivery rates in the short term, a 14% decrease in caesarean section rates (Gibbons et al., 2010; Lauer et al., 2010). According to Lauer et al., the growth rate in caesarean delivery can therefore be considered a “conventional economic good” driven by demand and choice (2010, pg. 9). Similarly, McAra-Couper et al. (2012, pg.11) described the “normalisation of surgery” among women and health professionals as a threat to normal birth rates. The authors argued that the normalisation risks promoting caesarean section as almost another “market commodity” with parallels to the choice of having cosmetic surgery.

A second model – the “supply-driven model” holds that regardless of medical needs, the greater the health system's capacity to provide surgical, obstetric services to consumers, the greater the expected rate of caesarean delivery (Lauer et al., 2010). In essence, health care providers (mainly obstetricians) can influence delivery mode and are essential contributors to

the growth in the rates of caesarean utilisation. Therefore, the capacity of the health system to provide adequate choice for maternity care is a crucial factor in driving rates of caesarean section. (Goyert, Bottoms, Treadwell, & Nehra, 1989; Lauer et al., 2010).

In comparative terms, more developed regions have an estimated rate of 21.1%, with 14% observed in less developed countries. Conversely, the global South have the lowest caesarean section estimated rates of only 2% at the population level, with findings from studies suggesting a negative association between rates of caesarean delivery and mortality outcomes for low caesarean delivery rates (Betran et al., 2016; Gibbons et al., 2010; Ye et al., 2016).

The decline in the rate of vaginal birth after a CS (VBAC) is also identified as a contributing factor to the increasing global CS rates (Fong et al., 2016; Wu, Kataria, Wang, Ming, & Ellervik, 2019). In New Zealand, maternal requests account for nearly 50% of the annual caesarean delivery rate (Ministry of Health., 2015; 2016; 2017). Despite a 70-80% VBAC success rate and the associated maternal benefits, repeat CS rates has remained on a steady rise (Knight, Gurol-urganci, Meulen, Mahmood, & Richmond, 2013; Landon et al., 2004; Crowther, Dodd, Hiller, Haslam, & Robinson, 2012; RANZCOG, 2015; van der Merwe, Thompson, & Ekeroma, 2013). Several factors account for this trend. For example, advice from care providers can influence women's decision making around a repeat CS (Gholami et al., 2014). Perceptions of risk have contributed to maternity care providers' preference of a repeat CS compared to a VBAC. The concerns of the reported association between the trial of labour after CS is associated with increased emergency obstetric interventions, as well as increased maternal and neonatal morbidity and mortality (Neill et al., 2017). According to the Royal Australian and NZ College of Obstetricians and Gynaecologists (RANZCOG), the risk of a uterine scar rupture is about seven times per 1000 vaginal birth attempts, with a one in seven chance of a severe neonatal brain injury or death in such cases (RANZCOG, 2015).

Fawsitt et al. (2013) report a two-fold risk of maternal morbidities on women who choose a VBAC over an elective repeat CS. According to Carroll et al. (2003), the morbidity rate increased with other maternal demographic complications. A recent study by Shinar, Agrawal, Hasan, and Berger (2019) discovered a significantly higher risk of neonatal mortality in twin pregnancy. However, it found a lower risk of infection and uterine rupture in a trial of labour after CS. These studies highlight the evidence that, despite the many benefits of vaginal birth after CS, there is an increased risk of uterine rupture, blood loss, and infection associated with a VBAC.

The literature suggests a trend in the continuous rise in CS rates in NZ and globally, which evokes concerns about the risk and cost implications for childbearing women and health systems. Research has suggested that local and international strategies aim to reduce the rates and optimise the use of CS to focus on how these strategies improve maternal and neonatal outcomes (Betran et al., 2016).

2.3. Implications of caesarean section

Research on caesarean section and the impact on women's experiences have shown both short- and long-term psychological and physiological maternal and neonatal implications. This section discusses some of the significant complications reported in the literature.

2.3.1. Psychological impacts of caesarean section on women

Available literature indicates that posttraumatic stress disorders (PTSD) and anxiety after caesarean section is a common phenomenon among women (Ayers, Bond, Bertullies, & Wijma, 2016; Fenwick et al., 2015; Ryding, Wijma, & Wijma, 1997; Wijma, Ryding, &

Wijma, 2002). For a new mother and her family, PTSD is considered a severe condition. Globally, posttraumatic stress reactions affect around 7% of women after childbirth (Lopez et al., 2017). However, research suggests that obstetric and perinatal variables contribute significantly to the higher rates of postpartum PTSD among some women (Modarres, Afrasiabi, Rahnama, & Montazeri, 2012). For example, Harris and Ayers (2012) reported that women who have had obstetric complications are three times more likely to develop posttraumatic stress reactions. In other words, women who have a caesarean section, mainly, emergency caesarean section, are more likely to develop symptoms of posttraumatic stress (Benton, Salter, Tape, Wilkinson, & Turnbull, 2019; Karlström, Engström-Olofsson, Norbergh, Sjöling, & Hildingsson, 2007; Elsa Lena Ryding et al., 1997, 2004).

In relative terms, women who suffer postpartum PTSD are bothered by intrusive memories and thoughts that may inspire feelings of horror, fear, and helplessness that interfere with daily life activities (Bailham & Joseph, 2003). For example, the experience of PTSD may impact a woman's decision to continue routine medical care as this may recall her previous traumatic childbirth experience. Social isolation, loneliness, anger or depressive symptoms that characterise the experience of PTSD make it difficult for women to bond with and care for their newborn and affect sexual activities and subsequent pregnancies (Bailham & Joseph, 2003; Reynolds, 1997). In most cases, for women who suffer postpartum PTSD, heightened anxiety remains a common occurrence, especially towards the health of their newborns. The constant fear of the child's wellbeing or the child's likelihood of dying results in distressing memories of the birth experience (Affleck, Tennen, & Rowe, 1991). Emergency caesarean section tends to create more stress and a greater degree of anxiety than an elective caesarean section (Suwal, Shrivastava, & Giri, 2013). In an emergency CS, the mother and infant can

experience significantly more stress hormones, which sets in a cascade of possible psychological episodes (Lopez et al., 2017; Ryding, Wijma, & Wijma, 1997).

Evidence suggests that women who deliver by CS are generally less satisfied with the birth than women who have a vaginal birth (Baston, 2006; Boyce & Todd, 1992; Sadat, Abedzadeh-Kalahroudi, Atrian, Karimian, & Sooki, 2014). This dissatisfaction contributes to low self-esteem, a sense of failure and inadequacy, guilt, post-operative anxiety, and depression. Potentially, it has a long-term impact on women's quality of life after childbirth, their relationship with their new-born, and their overall wellbeing (Clement, 2001; Dickinson, 2014; Dunn & O'Herlihy, 2005; Garel, Lelong, Marchand, & Kaminski, 1990; Ko et al., 2015; Sadat et al., 2014; Somera et al., 2010; Wijma et al., 2002).

Historically, major surgeries such as caesarean section were associated with the use of general anaesthesia. More recently, regional (epidural and spinal) techniques provide effective anaesthesia for caesarean section (Parsons, Cyna, & Middleton, 2004; Portnoy & Vadhera, 2003). In balancing risks and benefits, both for the mother and the child, regional anaesthesia (epidural or spinal) remains a preferred option due to shorter onset time, effectiveness, and a limited chance of the medication passing to the unborn child through the placenta (New Zealand Society of Anaesthetists, 2016). However, the use of anaesthetics during major surgeries is also associated with the experience of cognitive impairment, such as memory deficit or inability to recall the events during surgeries (Zurek et al., 2014). The impact on the woman can be negative, particularly if she feels she had passively 'participated' in the birth process as she would have liked (Burcher, Cheyney, Li, Hushmendy, & Kiley, 2016; Churchill, 1997; Dunn & O'Herlihy, 2005; Handelzalts et al., 2017; Porter, Teijlingen, Yip, & Bhattacharya, 2007; Saisto, Salmela-Aro, Nurmi, & Halmesmäki, 2001; Sargent & Stark, 1987). Women are seen to cope better and are more

satisfied with their birth experience if they have participated more in the delivery process. However, operative deliveries associated with potent anaesthetics make this problematic (Morgan, Bulpitt, Clifton, & Lewis, 1982; Robinson, Salmon, & Yentis, 1998).

DiMatteo et al. (1996) explored immediate and long-term satisfaction with birth among women who had a caesarean delivery compared to women who delivered vaginally. They reported that having an unplanned caesarean delivery was more likely to predict dissatisfaction with the birth experience than a planned caesarean. Findings by Burcher, Cheyney, Li, Hushmendy, & Kiley (2016) corroborated the earlier study. The authors found that dissatisfaction with birth experience due to caesarean delivery is exceptionally higher among unplanned CS women. In addition, a sense of loss, lack of control, and powerlessness during an unplanned CS contribute to the negative birth experience (Burcher et al., 2016).

Many women view childbirth as a notable event, and caesarean section, especially if unplanned, is perceived as a loss of this experience. Though studies of women's dissatisfaction with a caesarean delivery have increased in the last two decades, very little is known of the underlying factors of distress that contribute to this feeling (Porter et al., 2007). Therefore, it is pertinent that future studies explore the factors that women identify as distressing to understand better maternal satisfaction with caesarean delivery and resulting support needs. The current research attempts to fill this need.

A traumatic birth experience is associated with maternal postnatal depression (Bell & Andersson, 2016; Rauh et al., 2012; Sadat et al., 2014; Sword et al., 2011; Xie et al., 2011). However, postnatal depression and anxiety can be interpreted as low mood and irritability among new mothers rather than a psychological reflection of a significant traumatic surgical birth experience (Henshaw, Foreman, & Cox, 2004). This often reduces emotional and

psychological reactions after caesarean delivery to the experience of ‘baby blues’ after birth, which is considered benign and brief (Churchill, 1997; Henshaw et al., 2004). In addition, the challenges experienced with caring for her newborn post-caesarean can exacerbate depressive feelings, as the woman may find that her ability to care for her child falls short of her pre-birth expectations (Ateneo, 2015).

Gottlieb and Barrett (1986) explored the effects of unplanned caesarean delivery on women during the perinatal period and one month after delivery. The study found increased incidents of depressiveness and more difficult recovery among women with unplanned CS. Similarly, Lydon-Rochelle et al. (2001) reported that women who had caesarean deliveries experienced significantly lower general health scores at seven weeks postpartum than women who had a vaginal birth. In addition, values for mental health, physical functioning, social functioning, bodily pain, daily activities, and general health perceptions were also significantly lower among caesarean mothers (Lydon-Rochelle et al., 2001). Xie et al. (2011) also reported a higher postpartum posttraumatic depression rate (21.7%) among women who had a CS when compared with women who birth vaginally (10.9%).

However, some researchers have argued that the differences in postpartum mental health by mode of delivery (MOD) may also reflect pre-existing differences in mental health conditions among women (Adams, Eberhard-Gran, Sandvik, & Eskild, 2012). For example, Sword et al. (2011) argued that MOD has no significant impact on the presentation of PPD among women six weeks after discharge from hospital. Other social factors (such as maternal age, low mental health functioning, low social status, a higher number of unmet hospital needs, hospital readmission, low social support, poor physical health) interact with MOD to predict risk for postpartum depression (Sword et al., 2011). Therefore, MOD may not independently be associated with postnatal depression but confounded by other sociodemographic variables.

Adams, Eberhard-Gran, Sandvik, and Eskild (2012) used the 'Hopkins Symptoms Checklist-25 (SCL-8)' psychiatric disorder screening tool to examine the association between postpartum emotional distress and MOD among 55,814 Norwegian women, six months postpartum. They found similar incidents of postpartum emotional distress among CS and instrumental vaginal birth women six months postpartum. Though, compared to women with unassisted vaginal delivery, lower SCL-8 scores were found.

Where adequate information on the maternal mental health conditions before and during pregnancy are lacking, the findings of an association between caesarean section and higher levels of psychological distress and depressiveness are more likely. Thus, differences in postpartum mental health by MOD may reflect pre-existing differences in mental health conditions among the mothers.

Ko, Lin, and Chen (2015) investigated the relationship between unplanned CS and maternal stress and sleep quality using the Pittsburgh Sleep Quality Index (PSQI). Of the 200 participants, 23 (11.5%) women had an unplanned CS, and 90.5% of the women studied experienced poor sleep quality and stress after birth, with no significant causal relationship between unplanned CS and poor sleep quality. However, the potential for postpartum sleep distress is higher with the experience of postoperative pain and uterine contractions among caesarean mothers. Similarly, Tzeng, Chen, Chen, Wang, & Kuo (2015) found sleep disturbances until six months postpartum among 139 Taiwanese women who had a CS, noting that pain from the surgery was a crucial factor in the experience of sleep problems. In both studies, however, most women were reported to have higher PSQI scores related to pre-birth stress and anxiety about childbirth. These variables can also account for the experience of poor sleep trajectories among the study participants, as reported in other studies (Dørheim, Bjorvatn, & Eberhard-Gran, 2014; Hall et al., 2009).

Lack of sleep impact childbearing women's general health and well-being (Teong, Diong, Omar, & Tan, 2017; Henshaw et al., 2004). Insufficient sleep and poor sleep quality increase by 12% the chances of adverse health outcomes, including death (Cappuccio, D'Elia, Strazzullo, & Miller, 2010). Sleep disruption increases the risk for other postpartum morbidities such as depression, anxiety, stress, fatigue, and infection (Pairman, 2010). Consequently impacts the new mother's recovery from the caesarean operation following hospital discharge and even her transition into motherhood.

Bonding between a mother and her newborn is a specific, unique, deep-rooted emotional connection developed from the initial contact between a woman and her newborn (Klaus & Kennell, 1976). The mother-child bonding is strengthened by contact, proximity, and interaction, a bi-directional process[5] that develops progressively and crucial for the child's development (Stern, 1998; Taylor, Atkins, Kumar, Adams, & Glover, 2005). Adequate interaction between a mother and her newborn immediately after birth is essential for bonding (Figueiredo et al., 2009). During this period, continuous interaction helps a mother respond more affectionately to her newborn in the postnatal period (Figueiredo et al., 2009; Klaus & Kennell, 1976b; Taylor, Atkins, Kumar, Adams, & Glover, 2005). The inability of a mother to develop a close emotional relationship characterised by shared affection may have a long-term impact on both the infant and the mother (Taylor et al., 2005).

Early separation after caesarean delivery can be a trigger for disruption of attachment and bonding between a mother and her newborn (Darvill, Skirton, & Farrand, 2010; Swain et al., 2008; Trowell, 1982, 1983). Evidence shows that increased depression and maternal trait

[5] Bi-directional process - where both the mother and the infant play important roles in building the mother-infant attachment.

anxiety are associated with more extended periods of separations between a mother and her infant as a result of operative deliveries (Hankins, Clark, & Munn, 2006; Rauh et al., 2012; Sword et al., 2011; Xie et al., 2011). Figueiredo, Costa, Pacheco, and Pais (2009) found that obstetric and psychological complications can negatively impact mother-infant bonding. Trowell (1983) explored the mother-child relationship and bonding capacity with a group of women after an emergency caesarean delivery. He discovered lesser periods of eye contact and bonding between the mothers and their newborns, a lack of confidence in motherhood responsibilities, and intense feelings of disconnection among women who had a caesarean delivery. He further argued that the occurrences could be connected to the 'post-operative amnesia' women go through immediately after CS. This affects the recollected first contact of the mother with their infants and "set in chain a pattern of non-responsive or bombarding interactions between the mother and child" (Trowell, 1983, pg. 6). Following a caesarean delivery, incisional pain, fatigue, drowsiness, and discomfort can affect the mother-to-child emotional bonding with possible short and long term implications (Clement, 2001; Karlström, Engström-Olofsson, Norbergh, Sjöling, & Hildingsson, 2007; Liu, Raju, Boesel, Cyna, & Tan, 2013). Post-delivery separation of a mother and her infant may occur due to an infant's respiratory complications after a CS (Jain & Dudell, 2006). The separation, often a routine practice following surgical and instrumental delivery, can negatively impact early mother-infant bonding and may contribute to maternal emotional burden (Ayala, Christensson, Velandia, & Erlandsson, 2016; Rowe-Murray & Fisher, 2001, 2002).

Emergency or unplanned CS can put mothers at risk of experiencing psychological health challenges given the unexpected and sudden nature of the birth. Therefore, it is essential to understand the impact of these challenges on women's psychosocial outcomes and the long-term health and well-being implications.

2.4. Physiological impact on women

As a major surgical operation, caesarean section is associated with a higher morbidity rate when compared with women who deliver vaginally (Churchill, 1997). According to Engelkes and Van Roosmalen (1992), about 15% of all caesarean sections result in severe maternal morbidity. Currently, research has shown that there is an increased risk of wound infection, urinary tract infection, haemorrhage, pelvic and abdominal organ injury, thrombosis, endometriosis, and complications with anaesthesia for a caesarean birth (Field & Haloob, 2016; Filippi, Ganaba, Calvert, Murray, & Storeng, 2015; Ko et al., 2015; Lin, Hu, & Lin, 2008). In addition, CS remains associated with other perioperative morbidities, such as uterine rupture, bowel or bladder injury, and placenta accreta[6] compared with a vaginal delivery (Molina et al., 2015). Compared to vaginal delivery, women with CS are more likely to experience postpartum puerperal infection, hysterectomy, wound hematoma, cardiac arrest, and venous thromboembolism (Liu et al., 2007).

Lanska and Kryscio (2000) identified caesarean section as a significant risk factor for postpartum stroke and cerebral venous thrombosis (CVT) in the early postpartum period. Lin, Hu, and Lin (2008) noted that the hazard ratio of postnatal stroke among women who deliver by caesarean operation was 1.67, 1.61, and 1.49 times higher within 3, 6, and 12 months respectively after delivery, compared to women who delivered vaginally. Previous studies have also noted that caesarean delivery raises the risk of thrombosis and high degradation of fibrin products during and immediately after the operation (Bonnar, Davidson, Pidgeon, &

[6] Placenta accreta - a condition where blood vessels and other parts of the placenta remain deeply attached to the uterine wall instead of detaching after childbirth (Liu et al., 2007).

Mcnicol, 1969). Furthermore, Ravikumar and Prasannakumar (2016) posit that caesarean section increases by three-fold the risk for cerebral venous thrombosis during the puerperal period. Surgical-induced tissue damage during CS activates the blood clotting process, which is associated with thrombin generation. In turn, it accelerates the clearance from plasma and activation of protein-C that result in the decline of protein-C levels, thus increasing the risk for CVT (Bonnar et al., 1969; Dadheech, Khandelwal, Chauhan, & Sharma, 2016; Ehler, Kopal, Mrklovský, & Kostál, 2010; Lanska & Kryscio, 2000; Ravikumar & Prasannakumar, 2016). In the postpartum period, women who deliver by caesarean section exhibit increased activation of coagulation more than women who had a vaginal delivery. Blondon and colleagues studied the link between caesarean section and postpartum venous thromboembolism (VTE). Their study revealed that women are four times more likely to suffer venous thromboembolism after caesarean delivery in comparison to those who deliver vaginally (Blondon et al., 2016). This study also highlighted that caesarean section acts independently as a risk factor for VTE development in the puerperal period with greater risk in an emergency or unplanned caesarean section.

Major surgical operations are also primarily linked to mild and chronic pain with short- and long-term experience (Macrae, 2001). Evidence suggests that CS can result in postsurgical chronic and persistent pain (Bogod, 2016; Bruce & Quinlan, 2011; Grace, Greer, & Kumar, 2015; Jin et al., 2016; Kabakian-Khasholian, 2013; Kealy, Small, & Liamputtong, 2010; Neil et al., 2015; Wang, Wei, Xiao, Chang, & Zhang, 2018). Women who undergo an unplanned CS report higher rates of pain complications (Karlström, Engström-Olofsson, Norbergh, Sjöling, and Hildingsson, 2007; Grace et al., 2015). However, there is a paucity of qualitative research documenting women's experience of unplanned CS. Even fewer qualitative studies have focused on postnatal pain complications. There is a need to generate a more

comprehensive understanding of women's recovery accounts and dealing with pain complications following an unplanned CS.

2.5. Caesarean Section and the impact on infants

The literature on the long-term impact of CS on the child is limited. Some studies have explored the effects on the infant in the first few months after delivery and have reported the occurrence of respiratory distress and increased admissions of infants into intensive care units after CS (Annibale, Annibale, Hulsey, & Hulsey, 1995; Hook, Kiwi, Amini, Fanaroff, & Hack, 1997; Jain & Dudell, 2006). CS increases the risk of infant respiratory difficulties such as transitory tachypnoea. It also complicates hypoxic respiratory failure and respiratory distress syndrome due to iatrogenic prematurity (Hansen, Wisborg, Uldbjerg, & Henriksen, 2008; Heritage & Cunningham, 1985; Hook et al., 1997; Jain & Dudell, 2006; Keszler, Carbone, Cox, & Schumacher, 1992; Parilla, Dooley, Jansen, & Socol, 1993; Ramachandrappa & Jain, 2008; Roth-Kleiner, Wagner, Bachmann, & Pfenninger, 2003).

Respiratory distress syndrome is less common among infants whose mothers are allowed to go into labour before the caesarean operation, suggesting that labour is physiologically associated with an infant's preparedness for birth (Cohen, 1977; Hook et al., 1997). The transitioning of the baby's lung from one filled with fluid to one filled with air is reported to be facilitated by labour processes but becomes a significant challenge for the infant when labour fails to progress (Ramachandrappa & Jain, 2008; Smith & Kroeger, 2010). Evidence also suggests that the shock of a caesarean delivery impacts not only the infant's ability to breathe normally but also their ability to initiate sucking at the early stages of breastfeeding which may pose a long term negative consequence on the mother-child attachment (Hansen

et al., 2008; Ramachandrappa & Jain, 2008; Roth-Kleiner et al., 2003; Smith & Kroeger, 2010).

Previous studies have suggested an association between mode of birth, infant exposure to maternal vaginal and faecal microflora, and infant microbiota development (Dominguez-Bello et al., 2010). Infants' exposure to maternal microflora during birth is reported as essential for gut health establishment and can predict childhood overweight and obesity (Song, Dominguez-Bello, & Knight, 2013). On this note, babies born by caesarean section (particularly elective CS) are at higher risk of childhood overweight/obesity (Ajslev, Andersen, Gamborg, Sørensen, & Jess, 2011; Barros et al., 2012; Goldani et al., 2011; Huh et al., 2012; Kuhle, Tong, & Woolcott, 2015; Rooney, Mathiason, & Schauberger, 2011; Zhou et al., 2011). The bacterial exposure of the newborn results in differences in intestinal colonisation in comparison to a vaginal delivery which may constitute a physiological/metabolic risk factor in the gut of the infant and may contribute to overweight/obesity in the later stages of an infant's life (Flemming, Woolcott, Allen, Veugelers, & Kuhle, 2013). Huh et al. (2012) discovered a twofold increased risk of childhood obesity for infants born by caesarean section in a cohort of 1255 children born between 1999 and 2002 in Boston, Massachusetts, even after adjusting for birth weight, maternal body mass index, and other confounding variables.

Similarly, Barros et al. (2012) hypothesised an association between caesarean section and the risk of childhood and adolescent overweight/obesity. Studies on the association of caesarean section and childhood overweight/obesity have, however, had conflicting results. Ajslev, Andersen, Gamborg, Sorensen, and Jess (2011) reported that delivery mode (caesarean section versus vaginal) alone was not associated with childhood overweight/obesity. Instead, a combination of confounding variables such as maternal pre-pregnancy body mass index,

infant antibiotics use during the first six months after birth and delivery mode may potentially combine to influence the risk of childhood overweight/obesity. In addition, Flemming, Woolcott, Allen, Veugelers, and Kuhle (2013) reported a non-causal relationship between caesarean section and childhood overweight/obesity but implicated maternal body weight as a viable contributing factor. Though Masukume et al. (2018), using evidence from the *'Growing-Up-in-Ireland cohort study',* found that children born by emergency caesarean section had an increased risk of childhood obesity, they did not find a sufficient causal relationship with planned CS. A further study by Masukume et al. (2019) identified an association between childhood obesity and planned CS in the short term - but not emergency CS - in an analysis of the *'Growing-Up- in-New Zealand cohort study'*. These conflicting findings suggest epidemiological ambiguity on the relationship between childhood obesity and CS. It further indicates that the association between the exposure to vaginal microflora and childhood overweight and obesity may be subject to other biological and social conditions.

Women who deliver through CS are more likely to be administered anaesthesia and analgesic than those who have a vaginal birth (Bogod, 2016; Churchill, 1997; Field & Haloob, 2016). The effects of this anaesthesia and analgesia on the infant remain unclear. However, there are suggestions that these impacts negatively on the infant's health and wellbeing. For example, with time, all administered medications to the mother are transported into the umbilical veins via the placenta, and common postnatal analgesics can minimally transfer into the mother's breast milk (Littleford, 2004). Besides, maternal hypotension, a common problem associated with the administration of anaesthesia for CS, is associated with 'foetal acidosis and base

excess'[7] in infants (Littleford, 2004; Mavridou, Stewart, & Fernando, 2013). Anaesthetics and analgesics can impact the infant's experience of respiratory distress and sucking inhibition, with a resultant delay in effective feeding (Arnaout, Ghiglione, Figueiredo, & Mignon.

2.6. Caesarean Section and the impact on family dynamics

The impact of the birthing experience is crucial in women's postnatal well-being. Thus, researchers have argued the importance of birth models that enhance women's active involvement during labour and childbirth (Clement, 2001; Mutryn, 1993; Schorn, Moore, Spetalnick, & Morad, 2015). However, caesarean birth, especially when unplanned, can negatively impact women's perception of control. In most cases, physical separation of the woman and the newborn is common, contributing to increased psychosocial stress (Sittner, DeFrain, & Hudson, 2005). Studies have also highlighted the psychological impacts of caesarean births on partners/fathers. Some researchers claim that a father's relationship with his infant tends to be optimistic after a caesarean birth (Ayala et al., 2016; Erlandsson, Dsilna, Fagerberg, & Christensson, 2007; Garel, Lelong, & Kaminski, 1987; Hwang, 1987a; Velandia, Uvnäs-Moberg, & Nissen, 2012). This relationship may be due to mothers being less involved with baby care during the postoperative recovery phase of the caesarean birth (Clement, 2001; Edelstein et al., 2015). Against the preconceived supportive role to the mother, partners generally experience a sense of inadequacy, stress and anxiety over having to perform the function of the lead carer for the new-born (Ayala, Christensson, Velandia, &

[7] Metabolic imbalance in the concentration of hydrogen ion in the tissues (Bobrow & Soothill, 1999)

Erlandsson, 2016; Garel, Lelong, & Kaminski, 1987; Hwang, 1987b; Johansson, Rubertsson, Rådestad, & Hildingsson, 2012; Lee, 1986; Mutryn, 1993; Sargent & Stark, 1987; Yokote, 2007).

Evidence shows that admissions of infants into intensive care units after birth creates a considerable amount of stress for the parents (Lefkowitz, Baxt, & Evans, 2010). When a newborn is in a neonatal intensive care unit, the father often experiences a sense of anxiety and loss of control (Anisfeld & Lipper, 1983). This feeling is worse when the mother, due to the CS complications, also requires intensive care and cannot offer care to or bond with her newborn (Ray, Urquia, Berger, & Vermeulen, 2012). The situation is complicated in an inter-facility separation, where the mother and her newborn are in separate locations or facilities within the hospital. According to Ray, Urquia, Berger, & Vermeulen (2012, pg. 956), "this separation would magnify the degree of mother-infant and family discord and stress and could create competing priorities for family members in terms of decision-making and support".

A woman's feelings about her childbirth experience may shape her thoughts around the discharge of her perceived maternal role (Churchill, 1997). Research shows that women who deliver by caesarean section tend to provide significantly less care for and experience more ambivalence towards their newborn in the immediate postnatal period (Affonso and Stichler, 1980 & Tulman, 1986. Cited in Churchill 1997; Figueiredo, Costa, Pacheco, & Pais, 2009; Lobel & DeLuca, 2007; Nyström & Axelsson, 2002; Porter, Teijlingen, Yip, & Bhattacharya, 2007; Trowell, 1983). Many women consider their childbirth experience as very important (Nilsson et al., 2013). Therefore, a negative perception of birth may adversely impact family dynamics. What is clear is that CS is an operative birth, and women who deliver through this means have to cope with the management of post-operative pains and longer physical,

emotional, and psychological recovery periods (Kealy et al., 2010). Support from partners and families is crucial for the woman at this stage. This support may be satisfactorily provided for some families and essential for the woman's overall recovery. However, this is not the case for most women (especially single mothers) who struggle to adapt and transition to motherhood and provide the nurturing and care needed for the newborn while trying to cope with their recovery (Hemanth et al., 2014; Taylor et al., 2005; Trowell, 1986; Weiss, Fawcett, & Aber, 2009).

For some couples, the challenges of a caesarean section may compromise future pregnancy decisions for both parents, especially in the absence of a robust support system and education (Shorten, Shorten, & Kennedy, 2014). Many couples may find it difficult to have in-depth discussions about the woman's birth experience after an emergency caesarean delivery. The thoughts of another pregnancy and children can remain dormant for long periods if not abandoned.

The relationship between sexual health outcomes and mode of delivery is linked to the early resumption of intercourse after delivery (Buhling et al., 2006; Klein et al., 2009; Safarinejad, Kolahi, & Hosseini, 2009). Hicks et al. (2004) and Gungor et al. (2007) highlight delays in sexual intercourse resumption among women who had vaginal delivery compared to a CS. Gungor et al. (2007) evaluated this impact. They found higher sexual dissatisfaction among women who had vaginal delivery than those who had a caesarean birth, mainly due to vaginal tear and perineal trauma.

However, Yeniel and Petri (2014) found no relationship between sexual function and mode of delivery. They reported that women's marital situation, lifestyle, and socio-demographic characteristics are important factors that impact postpartum sexual function. Faisal-Cury et al.

(2015) shared this view. They noted that the mode of delivery had no significant impact on the resumption of sexual activities among women who CS and those with complicated and uncomplicated vaginal delivery in the long term. The literature on sexual function and CS is divergent and inconclusive. Most of the studies that report no difference in sexual functions regarding mode of delivery were conducted between 6 to 32 months after birth, suggesting that the impact of mode of delivery on sexual function is limited to the early postpartum period.

Some authors have suggested a link between the increasing CS and high global infertility rates, though the relationship is more psychosocial than pathological (Bhattacharya et al., 2006; Porter, Bhattacharya, Teijlingen, & Templeton, 2003). Evidence shows that primigravidae (first-time) mothers who deliver through CS have fewer children (Norberg & Pantano, 2016; Porter et al., 2003), with the experience of physical and psychological trauma from a CS identified as a crucial factor affecting women's decision for future pregnancy (Garel et al., 1990; Roberts, 1992a).

A diverse body of research raises many possibilities for an association between CS and subfertility but lacks consistency. An earlier study by Hemminki et al. (1985) examined the association between CS and infertility in 406 primigravidae Scandinavian women, using a retrospective cohort study. They discovered that women who delivered by CS had lower fertility in comparison to the matched control group. The authors concluded that the difference in fertility rates between both groups was mainly due to difficulties bearing children among the caesarean group. Miscarriages, ectopic pregnancies, and placenta complications in subsequent births among the CS group are underlining factors contributing to fertility complications. Also, Hurry, Larsen, and Charles (1984) found a link between pelvic abscess following CS and subsequent infertility. Ananth, Smulian, and Vintzileos

(1997) reported an association between previous CS and subsequent placenta praevia (a high-risk factor of antepartum haemorrhage), which is associated with tubal factor infertility. Bahl (2004) reported higher rates of difficulty conceiving after a CS than instrumental vaginal delivery.

Similarly, Murphy, Stirrat and Heron (2002) found that there is an increased risk of a higher interval of one to three years or more between getting pregnant and conception among women who deliver by CS. Arguably, this association between subfertility and the CS was attributed to infection, placenta bed disruption, or pelvic adhesions. Despite these claims, current evidence to support the physio-pathological proof of impaired subfertility after a previous CS remains inconclusive. Leitch and Walker (1998), cited in Porter et al. (2003), carried out a retrospective, descriptive study examining obstetric records between 1962 and 1992 and established that unknown aspects of the caesarean operation can impact women's reluctance to have further children.

2.7. The case for a caesarean

Despite the reported implications and increasing rates of CS globally, researchers and health providers agree that CS is a critical medical intervention that helps prevent birth injuries and saves the lives of mothers and infants in obstetric risk situations (Begum et al., 2017). Caesarean section is safer, and survival rates have also increased, though records suggest that CS-linked maternal and infant mortality rates remain disproportionately high in low-income countries (Sobhy et al., 2019). Caesarean section has also promoted choice for women in childbirth as it presents an alternative for women who may, outside any medical condition, choose not to deliver vaginally (Douché & Carryer, 2011; Douche, 2007; Hull, Bedwell, &

Lavender, 2011; Ramachandrappa & Jain, 2008; Savage, 2007; Tully & Ball, 2013). More cynically, the increasing rate of CS is argued by some to be an indication of its importance. CS has evolved from being just an intervention for saving the lives of a mother or her infant during childbirth into a desirable birthing option for some women (Mander, 2007). The perception of caesarean birth as 'abnormal' can minimise the 'birthing aspect' of the delivery, consequently placing mothers who deliver through a caesarean section in a niche that can be regarded as being demoralising and degrading (Donovan & Allen, 1977; Mander, 2007).

CS remains a crucial medical intervention in childbirth which saves the lives of many women and infants during difficult birth (Muula, 2007). CS is among the medical and public health interventions that have contributed to lower maternal and neonatal mortality rates observed globally (Blencowe et al., 2016; World Health Organization, 2016). Though the historical use of CS was 'the last resort', in recent times, it has been integrated into the standard management of birth options for women due to its improved safety outcomes (Dickinson, 2014).

In the Global South, CS rates are observed to be inversely related to maternal and infant mortality rates (Betran et al., 2007). Usually, women in these countries who need the CS option are mostly denied it due to inadequate access to obstetric care. The rates in these countries are, therefore, among the lowest globally. Sadly, the maternal and neonatal mortality records remain high in the Global South (Althabe et al., 2006; Betran et al., 2007, 2016; Betran, Torloni, Zhang, & Gülmezoglu, 2016; Ronsmans, Holtz, & Stanton, 2006). For example, in 2014, the caesarean section in South Sudan and Somalia was less than 1%, and in the Central African Republic (CAR) and Chad, 5% and 2%, respectively (WHO, 2015c). However, maternal and infant mortality rates in these countries in 2015 were 789/100,000, 732/100,000, 882/100,000, 856/100,000 live births, respectively (WHO, UNICEF, UNFPA,

World_Bank_Group, & UNPD, 2015). Thus, making life-saving CS available for women with high-risk pregnancies in this region could contribute significantly to ensuring better maternal and neonatal health outcomes (Althabe et al., 2006).

2.8. Postnatal care after unplanned/emergency caesarean section

The urgency of the emergency caesarean section means that women may be ill-prepared physically and psychologically for a surgical operation, thus may have very little time to process the situation and prepare themselves to experience the caesarean birth (Somera et al., 2010). The impact of this lack of preparation plus the intrusive nature of the operation can affect women's ability to adjust well to the unanticipated and difficult circumstances around their unplanned caesarean birth and pose additional physical, emotional, and psychological postpartum stress to the woman (Handelzalts et al., 2017; Miovech et al., 1994; Ryding, Wijma, & Wijma, 1998; Wijma, Ryding, & Wijma, 2002).

The days and weeks after birth are demanding periods for a woman and her infant. The woman remains susceptible to life-threatening health complications as she experiences the many changes that occur to her body in the few weeks after birth (RANZCOG, 2017b). This makes postpartum care very important. The nature of the care the woman receives set the stage for her ability to nurture her infant and play a vital role in her long-term health and well-being (Stuebe, Auguste, & Gulati, 2018; WHO.

Access to timely and quality postpartum care promotes good outcomes for mothers and infants. Optimised postpartum care for women should meet women's individual needs and designed to meet demands across the different areas (physical, social, emotional, and psychological) of health and well-being (WHO, 2015a). Stuebe et al. (2018, pg. 141) propose

a policy shift incorporating a “fourth trimester” in the maternity care pathway to ensure comprehensive postnatal care for the woman and her infant. When an operative delivery is needed, the mother should have input on the nature of care required and the primary care provider responsible for her care and support. Also, considerable input of the obstetric specialist in the coordination and the timely follow-up of postpartum care services is essential (Stuebe et al., 2018).

In most cases, CS involves long term recovery period, depending on labour, delivery, and socio-demographic characteristics (Mousavi, Mortazavi, Chaman, & Khosravi, 2013; Hobbs, Mannion, McDonald, Brockway, & Tough, 2016). In some situations, there may be cases of perineal trauma, anxiety or psychological distress, injury, post-operative infection, chronic pain, complications with analgesia use, placenta praevia accrete (Field & Haloob, 2016; Filippi et al., 2015; Ghahiri & Khosravi, 2015; Kealy et al., 2010). Thus, creating substantial distress for the woman and her family poses considerable cost and strain on the health system (Guittier et al., 2014; Hobbs et al., 2016). These complications are more severe among women who deliver by emergency caesarean section, and recovery can extend beyond planned caesarean or vaginal birth (Hobbs et al., 2016). In light of this, extended care periods are usually needed by the woman, who not only needs time to recover and cope with the pain from a healing incision but is also expected to provide care in the form of breastfeeding and nurturing for the newborn (Ismail, Shahzad, & Shafiq, 2012; Kealy et al., 2010).

The midwifery scope of practice requires midwives to provide primary maternity care to low-risk women and ensure the protection and promotion of normal birth (International Confederation of Midwives, 2018; NZCOM, 2009). In New Zealand, women receive continuity of care from their LMCs during pregnancy to six weeks post-birth, and over 85% of women chose a midwife as their LMC (Davis & Walker, 2011; Ministry of Health, 2017).

However, midwives in New Zealand continue to be involved (often as secondary carers) in providing care to ‘high risk’ women under obstetric care (Skinner & Maude, 2015). Irrespective, there is limited knowledge on the impact of an emergency operative delivery on the experiences of women who receive midwifery continuity of care in New Zealand. This research, therefore, seeks to bridge this gap in the literature.

In summary, The experience of an unplanned caesarean section is memorable and transformative for most women, especially when it is traumatic and life-threatening to the woman and her child (Karlström, 2017). A caesarean operation is an episodic event that is part of the broader assemblage of the birth experience. How women make sense of the social processes of an unplanned caesarean birth has received little attention, even in Western maternity health systems (Rodríguez-Almagro et al., 2019). However, in the context of the woman’s experience, these seemingly everyday events are episodes of high significance to women, remarkably when expectations around these aspects of their care experience are abruptly changed, ignored, or disregarded (Cook & Loomis, 2012). Maternity care expectations can change abruptly, which can have potential consequences on maternal well-being, and women can read these as disruptive changes (Crowther, Smythe, & Spence, 2014; Kuliukas, Hauck, Lewis, & Duggan, 2017).

Summary

This chapter discussed the evolution of caesarean section and how risk perception has contributed to the rise in medical interventions in childbirth - which remains a keenly debated topic in maternity care. Caesarean section is considered a major medical intervention that has seen increased use over the years, especially in high-income countries, despite its overuse and

maternal and neonatal health and well-being implications. Risk perception has become a part of modern maternity service and is linked to the increasing CS rate and other medical interventions. The chapter has demonstrated how historical and contemporary risk discourse, present as an undercurrent, have been shaped by professionals to present ‘risk’ as an inevitable part of childbirth and how in particular, women have not just remained the recipients of this discourse but in some ways as communicators. The chapter also highlighted the argument on the importance of caesarean section, not only as a medical intervention that prevents birth injuries and saves the lives of women and their babies but also as a tool to promote choice for women.

Chapter Three: Feminist Perspectives

3.0. Introduction

This chapter discusses the theoretical framework - poststructuralist feminism - which informs the study methodology. Linking with the previous chapter, the first part of this chapter summarises the social construction of caesarean birth. It draws from the discourse of pathology used to characterise the female body and how this has carved a new conception and management of childbirth. The chapter includes a discussion of women's health from a feminist perspective. Then the literature on midwifery evolution and the historical outlook of childbirth in New Zealand from a feminist viewpoint. Finally, the chapter ends with a description of the current lead maternity care model in New Zealand and a view of the effort in building a collaborative maternity system challenged by professional disciplinary tensions.

3.1. Social constructionist view of caesarean birth

Social constructionism conceptualises the nature of reality, essentially constructing observations as an accurate reflection of the social environment (Murphy, Dingwall, Greatbatch, Parker, & Watson, 1998). Childbirth experiences vary among women, and socio-cultural, environmental, and medical factors account for these differences (Oakley, 1980). Though childbearing is a common biological phenomenon (Donegan, 1987), the experience of childbirth is also socially constructed as it occurs within defined cultural practices and shaped by perceptions, norms, and expectations (Behjati-Ardakani, Navabakhsh, & Hosseini, 2017; Roberts, 1992b). For example, the socio-cultural constructs of 'fear of labour pain' affect perceptions and attitudes towards childbirth which considerably impact the choice of

birth method (Zakerihamidi, Latifnejad Roudsari, & Merghati Khoei, 2015). Social constructionism as an epistemology will be explored further in Chapter Four.

As CS became more common, criticisms of the implications for women mounted. Many have criticised the normalisation of surgical birth. They argue it is 'the modern way of childbirth', particularly in western countries where surgical delivery is viewed as "designer birth" (Panazzolo et al., 2011, pg. 269). In contrast, birth without intervention is considered 'old-fashioned' (Kingdon et al., 2009; Lavender & Kingdon, 2006). In Bergeron's view, the narrative of intervention-free birth as 'old fashioned' is underpinned by a "sexist bias" of the medical model of childbirth. She argued that while women's freedom of choice, as reflected in the option for caesarean birth, is regarded as reproductive autonomy, the normalisation of medicalised birth is unrelated to women's aspirations, goals, and priorities (Bergeron, 2007, pg. 480).

Similarly, McAra-Couper et al. (2012) posit that choice in this instance is determined and influenced by the context in which a surgical birth such as a caesarean delivery is becoming the norm. Consequently, just as the medicalisation of birth has compromised indigenous birth knowledge (Stojanovic, 2012), there are concerns that the normalisation of surgical delivery may compromise women's body of knowledge around normal childbirth. In turn, we may see the dominance of discourses of birth increasingly constructed and informed by the normalisation of surgical delivery.

Critics have argued that the language used to pathologise birth treats women's bodies during pregnancy and childbirth as a 'disease state' that requires medical intervention rather than a 'normal/natural' physiological event (Prosen & Krajnc, 2019; Simkin, 2012). As women's bodies were reduced to convey medical assumptions of risk, childbirth became "something

that was performed on a woman, rather than something women performed" (Luce et al., 2016, pg. 5). Cohen and Estner (1983, pg.161-165) described in their text that this has carved "a new image of childbirth" in westernised countries, where doctors infer women's bodies as 'defective' and, if unassisted in childbirth, is likely to produce a "less than perfect baby". Ironically, while women are made to feel like they are a 'disease' that needs to be treated urgently before the caesarean operation, this conception changes after the birth. The woman is expected to transition quickly into motherhood. Unlike the type of care provided and the long period of recovery expected for patients after major abdominal surgery, after caesarean section, the mother is expected to take responsibility for the care of her newborn (Hillan, 1992; In Roberts, 1992). Thus, women's experience of medicalised birth is largely interpreted from the perspectives of medical professionals.

For a woman who planned for a natural (vaginal) birth, a difficult birth that results in an unplanned caesarean section can complicate her birth experience (Reenen & Rensburg, 2013). In literature about caesarean section and women's experiences, negative psychological, psychosocial, emotional and physical experiences among women are commonly reported (Adams et al., 2012; Dickinson, 2014; Field & Haloob, 2016; Ghahiri & Khosravi, 2015; Grace et al., 2015; Porter et al., 2003). However, not all women who deliver by caesarean section report a negative experience. For example, Sword et al. (2011) noted that post-natal depression was not independently associated with mode of delivery (MOD). Instead, factors such as maternal age, low mental health functioning, low social status, unmet hospital needs, low social support, and poor physical health interact with MOD to predict the risk of postpartum depression.

Similarly, Adams et al. (2012) found no significant association between (MOD) (caesarean section) and post-partum emotional distress at six months postnatal. However, the authors

found that the fear of mental trauma during pregnancy had a more significant impact on the experience of post-partum distress among a cohort of Norwegian mothers. Also, Reenen & Rensburg found that women who receive practical and straightforward information before an unplanned caesarean section reported feeling prepared, which enhanced positive perceptions of their birth and improved outcomes (Reenen & Rensburg, 2013).

Individual reactions or responses to challenges and threats are entrenched within an intricate web of socio-cultural experiences, including biological and physical characteristics, family, cultural and social factors, or even the characteristics of the event itself. These factors, either singularly or by intersection, impact how an individual perceives, accepts, frames, evaluates, interprets, and reacts to such events (Amirkhan & Greaves, 2003; Hamilton & Lobel, 2008; Strümpfer, 2006; Reenen & Rensburg, 2013). Perhaps, this account for differences in an individual birth appraisal or post-caesarean psychological sequelae among different women (Clement, 2001). Therefore, a woman's birth expectation, attitude, perception, and unique attributed meaning towards childbirth influence her perceived satisfaction, achievement, and self-esteem (Gibbins & Thomson, 2001; Reenen & Rensburg, 2015). Psychological vulnerability, socio-cultural factors, and pre- and post-natal care that she receives can play a role in how the woman perceives or reacts to her caesarean birth (Gibbins & Thomson, 2001).

3.2. Feminism and women's health

Feminism is grounded on women's experiences. It recognises the inequalities between men and women, which stems from politically motivated societal gender-based constructs (Alcoff & Potter, 1993; Hunter, 1996). Feminism as an ideology rooted in the women's liberation

movement emerged in the 1960s (Bryson, 1992; Weedon, 1997; Willis, 1984). It was concerned with equal opportunities for women and men in education, welfare systems, voting rights, employment, and the conflicts around women's social roles in society (Willis, 1984). It challenges the power relations that exist in society between both genders and criticises how these power relations have promoted women's subordination. Gender relations determine life opportunities, experiences, and people's roles in society (Weedon, 1987, 1997). This power relations structure almost every area of life; the family, occupation, income, health, politics, culture, and women's reproductive rights (Ruzek, 1978). For example, during the 1960s, abortion rights were strictly limited in many states in the United States except when performed to save a woman's life. This restriction resulted in over a million illegal abortions performed yearly. Nearly half of the women involved in unlawful abortion require hospital admissions due to complications, and around 1000 deaths recorded annually from illegal abortion complications (Geary, 1995). Today, similar events are experienced globally, including in Western countries where women's reproductive rights remain subject to and continue to be influenced by the various political power structures that predominate in specific places. However, the impact reverberates across the globe (Pugh, 2019). As a direct response, feminists groups and women's activists pushed for and established movements advocating for women's abortion rights and other areas that affected women's health (Nichols, 2000). As the women's liberation movement broadened its scope to study patriarchal influences on societies, feminist theorists started embracing women's health care as an important area of research (Nichols, 2000).

A major milestone of this movement was the *women's health movement*, with its primary goal as promoting women's reproductive health rights. This movement was known internationally for pushing for the reclamation of power from the often condescending and

paternalistic medical system, as well as women taking control of their health and bodies (Nichols, 2000). Notably, in the United States, changing childbirth practices was a key focus for the women's health movement. Women campaigned to have their children born without medical intervention and also in the presence of their partners. The goal was for more choice, better childbirth preparation for expectant mothers through childbirth education, and family-centred maternity care (Nichols, 2000).

By 1970, the women's liberation movement had reached New Zealand. Campaigns, demonstrations characterised it, and social networks formed, championing women's rights and resisting society's authoritarian and patriarchal influence against women. These movements were instrumental in the eventual formation of the National Organisation of Women (NOW), and by 1973 the first United Women's Convention was held in Auckland. A key goal was a breakdown of the "sexist structure of the society" and creating a feeling of solidarity among women by increasing the awareness of the individual oppression that women experienced (Bryder, 2013, pg. 109). In particular, the new feminist movement pushed for the liberalisation of abortion laws as a means for women to reclaim the right of ownership over their bodies and the right to exert control over decisions concerning them. Later, the focus was on women's reproductive health, including reducing medical interventions in birth and promoting natural childbirth, with midwives supported by feminist activists championing this cause (Bryder, 2013).

New Zealand has seen some women's health movements influenced by international feminist ideologies, especially the developments in America in the early 1960s. A key theme for the movements was the opposition to medicalisation and the challenge of establishing networks working to champion women's reproductive health and rights (Coney, 1997). Feminists such as Sandra Coney and Phillida Bunkle began their activist careers creating awareness about

women's rights to ownership of their bodies, abortion, contraception, sex education, domestic violence against women, sexually transmitted diseases, and child abuse (Bryder, 2013; Coney, 1997). Both women later became famous for exposing a cervical cancer scandal (the 1960s - 1980s) at National Women's Hospital. Many women, without their consent, underwent several medical procedures mainly to observe rather than treat their condition (Metro, 1987).

Before 1970, significant policies around childbirth focused on humanising the hospital birth experience for women. Due to her personal experience of pregnancy and labour, Sandra Coney believed there had to be a shift in the paradigm away from women feeling an overwhelming sense of powerlessness (Bryder, 2013). Women's health groups in New Zealand, such as Maternity Action, Home Birth Association, and Save the Midwives, had broadened the women's health plan to reform the nature of care women receive through the de-medicalisation of childbirth. By mid-1970, the promotion of natural births and home births and restoring the autonomy of midwives became the key focus (Bryder, 2013; Coney, 1997). Two decades later, by 1990, the historical legislative changes in New Zealand instituted independent midwifery within the NZ health system and saw the emergence of shared care programs between doctors and midwives, which effectively increased women's choices (Kutinova, 2008). Today, these changes have evolved into the midwifery-led Lead Maternity Carer (LMC) system, which strives to reduce increased medicalisation of childbirth in New Zealand (Davis & Walker, 2011). The subsequent sections of this chapter discuss these changes in detail.

3.3. Poststructuralist feminist perspective

Over recent decades, feminism mounted challenges to patriarchal establishments and ideologies both in health care and sociology. Yet, feminist scholarship has seen both historical and ongoing internal and external divisions based on theoretical positions and ideological interpretations (Annandale & Clark, 1996). The poststructuralist feminist theory presents a valuable "conceptual foundation" to the feminist approach in building knowledge and giving meaning to lived experience (English, 2010, pg. 2; Gavey, 1989, pg. 460). Poststructuralist thinkers view 'reality' as a culture-specific and diverse construct produced through discourse, text, and language (English, 2010; Weedon, 1997). Therefore, language is an essential element in shaping cultural representations, identity, and 'social reality' (Galbin, 1996; Searle, 1995). Critical theorists and philosophers such as Derrida and Foucault, who have theorised the relationship between knowledge, language, and power, influenced post-structuralism (Agger, 1991). Poststructuralism is a deviation from 'structuralism', which emphasises the static structures of social systems and elements that determine interpretations and knowledge formations. Poststructuralist thinkers believe that social reality – what is truth – is constituted through 'discursive practices' (Bacchi & Bonham, 2014). Foucault used power and knowledge to highlight how dominant reality is created through power relations, noting that power asserts through language. Foucault refers to the practices of discourses to signify 'knowledge formation' and how accepted forms of knowledge constitutes power (Bacchi & Bonham, 2014; Downing, 2008; Foucault & Hurley, 1988; Hewett, 2004).

Poststructuralists rejects the view that all things exist within structures (structuralism) and that systems define reality (Weedon, 1997). They question the idea of a world of objective knowledge and reject assumptions of independently universal meaning or truth of reality. In language, poststructuralists focus on meaning derived from the complexity of a whole

language rather than the meaning from individual words. Hence, poststructuralists' interest in methods of analysis that seek to uncover multiple interpretations of texts (Harcourt, 2011). For example, Derrida inspired deconstruction (a central approach in poststructuralist readings) as a criticism against literary objectivism and pragmatism. Deconstruction highlights the challenges of traditional assumptions of 'meanings' in literary analysis. For Derrida, words or texts are contested terrains whose meanings are concealed within the language use of the authorial voice. Thus, the text's definition or 'meaning' emerges through 'literary deconstruction', which unravels the subjective assumptions and literary expressions that contextualise the text (Agger, 1991, pg. 112). Literary deconstruction is a poststructuralist concept that offers a challenge and an alternative to structuralism's traditional literary theories of how we read and write and conceptualise texts (Agger, 1991; Norris, 2002). Deconstruction does not attempt to locate meaning in a given text. Instead, it is interested in the process of how meaning is broken apart across texts. Typically, in the analysis of texts, language is assumed to be stable and with a fixed meaning. However, Derrida believed that language is uncentred and often does not hold a fixed meaning. To move beyond the indefinability of language, Derrida argued for the need to continually modify the language to get closer to its meaning (Derrida, 2016). Though in his view, we might fail in reaching the point where meaning is assured.

In deconstructing texts, we attempt to 'find' meaning rather than 'choose' or 'pick' meaning. We try to locate the 'binary opposites' (the privileged and repressed) in a text (Derrida, 2016; Norris, 2002). Derrida avoids objectivism by offering no singular way of deconstruction but provides a methodology of first decoupling texts or observations into parts and identifying the tensions present in the texts—secondly, identifying the agreements in the text that appear unified by meaning. In essence, in taking a deconstructive approach, meaning may often be

vague or ambiguous, assumed, or inferred, rather than assured (Agger, 1991). Further, by closely reading and analysing texts, we can resolve the tensions in texts and expose unquestioned assumptions about texts and language. Deconstruction is, therefore, concerned with the instability of meaning in texts. This view aligns with a poststructuralist ideology that conceptualises meanings as transactional, textually, and culturally constructed (Grosz, 1995; Jefford & Sundin, 2013; Smagorinsky, 2001).

Poststructuralism appealed to feminist theorists due to the new methods for understanding and reconstructing debates on knowledge, gender, culture, and social relations (Annandale & Clark, 1996). Key post-structural feminist theorists that have emerged include Felix Guattari, Rosi Braidotti, Hélène Cixous, Judith Butler, Gilles Deleuze, Julia Kristeva, Roland Barthes, Elizabeth Grosz, and Philippe Lacoue-Labarthe among others (Grosz, 1995; Hunter, 1996; St. Pierre, 2000; Weedon, 1987). In recent times, social transformation studies have shifted focus from how the knowledge that resides with the individual is used to shape the world to how subjectivity is constructed to shape reality (Annandale & Clark, 1996; Linstead, 1993). Feminist debates over women's shared characteristics have raged for many decades. Central to these debates was whether women share a unified experience that is uniquely common to all women that can mobilise collective action against the subordination and oppression of women globally (Dzubinski & Diehl, 2018; Hunter, 1996; Witt, 1995).

The notion that women share a singular identity and everyday experience (essentialism) is controversial within the feminist philosophical circle. Radical feminists took contrasting views from liberal feminists in endorsing essentialism and intrinsic connections between biology/sex and gender (Annandale & Clark, 1996). Essentialists believe that women's identity and characteristics are independent of any other belief, argument, or demonstration and claimed that women everywhere possess distinct characteristics due to biological/sex

identity (Crook, 2012; Raymond, 1999; Witt, 1995). “Biological determinism” was a view used to conceptualise women’s psychological and behavioural differences relative to men and provided grounds for the justification of social and political structures that oppressed women and sketched patriarchal conceptions of women’s identity, which confined women’s social positions and roles (Raymond, 1999; Willmott, 2016). Biological determinism views the totality of one’s identity (appearance) and being (behaviour, personality, psychology, likes and dislikes) due to their physical and genetic makeup, rather than culturally learned or the product of societal wider acceptance. This ideology has been expressed in the conception of race, gender and sexuality, and has historically been used to defend gender structures and women’s subordination/oppression (Raymond, 1999; Willmott, 2016).

Second-wave feminism made crucial theoretical advancements in separating biological and the socially-constructed notions of gender. The sex/gender separation was a crucial argument for the feminist movement. It presented an important tool for addressing women’s subordination and argued that psychological and behavioural differences have socio-cultural causes rather than being determined by biological makeup.

Radical feminists adopted the conception of “woman as a universal subject” as a narrative and ideology to cement the movement against biological determinism (McAfee & Howard, 2018, np). Radical feminists endorsed the intrinsic connection between sex and gender. They championed the category of ‘woman’ as a universal singular subject. They argue that the distinctive difference of women, the attributes of the female body, should be positively revalued and appreciated as a way to undermine patriarchal notions and privileges (Annandale & Clark, 1996; McAfee & Howard, 2018). However, the subject of ‘woman’ as a universal category is an essentialist ideology by second-wave feminist theorists, who viewed

gendered sexual differences as socially constructed (Hunter, 1996; McAfee & Howard, 2018).

Anti-essentialist and intersectional feminist perspectives (Crenshaw, 1989), were notably conceived by radical feminists as key fault lines in feminist understandings and conception of gender. Thus, they challenge the anti-oppression feminist movement (Bryson, 1992; Willis, 1984). Yet, contending with increasing internal resistance to its fundamentally essentialist assumptions, the conceptual foundation of the radical feminist movement lost its currency in the 1970s (Willis, 1984). Simultaneously, anti-essentialists and intersectional feminists rejected essentialism because it undermined women's diversities and was an exclusionist ideology (Diquinzio, 1993). For example, while radical feminists saw "essentialism as a political necessity", beneficial to all women (Stone, 2004, pg. 1), anti-essentialists felt that the idea that universally women share a 'common experience' was conforming to patriarchal constructions of womanhood and thus may present obstacles to the social- and symbolic differences in womanhood (Bem, 1993; Van Stapele, 2014; Willis, 1984). Therefore, many rejected the notion that women are a "coherent group with a singular identity" (English, 2010, pg. 2), with "fixed characteristic" and "given attributes" (Grosz, 1995, pg. 33), but argued that women's identities, characteristics, and experiences are diverse and intersecting (Crenshaw, 1989). Further, they challenged the ideology of essentialism which emphasised grounds for feminist politics but ignored race, ethnicity, gender, cultural diversity, religion, class, sexual orientation (Crenshaw, 1989; English, 2010; Witt, 1995)[11]. This division led to

[11] This view supports poststructuralist feminists' interpretation of gender identity, and illuminates feminist theory in conceptualising gender, womanhood and women's experience (Nicholson, 1990). It further highlights the complexities of intersectionality (of racism and gender inequality), which embodied early feminist movements (Crenshaw, 1989). For example, within women's groups, women of colour who championed their causes of racial and ethnic discrimination were shut down for the fear of jeopardising a 'greater goal' for the women's movement; such as the right of choice around sexual and reproductive health for all women universally (Crenshaw, 1989; Witt, 1995).

many feminists turning to separatism as an avenue to keep their movement, voice, autonomy, and politics alive (Willis, 1984). Many women of colour were omitted in these conversations. It was difficult to talk about race within gender spaces and gender within racial spaces even though both attributes make up the totality of the woman (Crenshaw, 1989; Hunter, 1996; Willis, 1984). Hence the rise to new theoretical approaches that have adopted a more critical view on women's experience, particularly the diversities that exist among women and across cultural and social frames. (Fraser & Nicholson, 1999; Witt, 1995). This theoretical shift contributes to the debates on gender and social identities and the value of intersubjective relations that mediate shared knowledge and meaning.

Rejecting essentialism but accepting the ethical and philosophical significance of feminist activism, I accept the contention that though women do not share static, indefinite, or common characteristics, they are part of and belong to a 'shared social group' (Stone, 2004). Hence, their participation in the complex history of the cultural construction of femininity. Stone's emphasis on recognising the concept of "genealogy" - which holds that each woman's experience overlaps in history with that of other women or groups of women - presents an alternative basis for reconstructing the feminist politics within which women's experiences and characteristics can be situated. Through this lens, "women can still exist as a determinate group, susceptible to collective mobilisation" (Stone, 2004, pg. 1 & 24).

3.4. Poststructuralist feminism, childbirth, and midwifery

Midwifery and feminism share foundational philosophies that have been established both in literature and in practice. Midwifery practice is grounded on the philosophy of women-centred care. It works on the premise that childbirth is a normal physiological process, and

women have the natural ability and should be supported to birth naturally/normally with minimal medical intervention (Fahy, 2012; Davis & Walker, 2011; Voon et al., 2017). Feminist research, as already discussed, acknowledges and emphasises women's lived experiences. Early feminist natural birth activists claimed that natural birth is the 'morally superior' form of childbirth that recognises and promotes a woman's natural capacity to birth and her right as an autonomous being to choose and control the events around her childbirth (Beckett, 2005; Beckman, 2014). The ideal of natural birth remains an ontological concept that is a popular narrative amongst feminist scholars today, offering a dichotomy to and strategy to counter dominant biomedical models of birth that is a tool in the continued control and suppression of women (Flavin, 2009; Petchesky, 1990; Shaw, 2013). Feminism has often used 'woman-controlled childbirth' and 'midwifery' both as rhetoric and philosophy to root for social changes in maternity care for women (Kay, Butter, Chang, & Houlihan, 1988; McAra-Couper et al., 2012; Westergren, Edin, Walsh, & Christianson, 2019; Yuill, 2012). Thus, studies exploring childbirth, women's rights, the midwifery profession, or the midwifery literature have a feminist focus (Davies, Daellenbach, & Kensington, 2011).

Feminists have used the assumptions and discursive rhetoric surrounding women's bodies (as consistently defective and unreliable) to theorise the female body and its role in women's oppression (Shefer, 1990). Popular perceptions of childbirth during the 19th and early 20th century pathologised the process and associated hospitalisation and obstetric-attended births as safe and the alternative as risky; feminist scholars claim these representations to have influenced women's perceptions of childbirth, creating a culture of fear over the pain and the danger of the process (Cahill, 2001). This pathological construction also served as a means for relocating control over childbirth to the medical profession. However, many feminist activists resisted this view. They countered the pathologising of birth with discourses of

'natural birth' as the 'norm', both as a response to the 'risk culture' and biomedical control over childbirth and women's bodies (Beckett, 2005).

The second-wave[12] feminist movement emerged alongside arguments that the conceptualisation of childbirth as 'a risky phenomenon' devalued the female body by defining women's bodies as unreliable and their capacity to birth naturally as questionable. It also suppressed the roles of midwives (a predominantly female profession) in maternity care (Davis-Floyd, 2003). The devaluation of women's bodies was linked to the technocratic model of birth, which considers the body a machine. In contrast to the male body, described as linear, consistent, and reliable, the female body was considered 'non-linear', 'unpredictable', 'unreliable' and more likely to malfunction due to its anatomical features (ovaries, uterus, breast) and biological functions (egg production/menstruation, pregnancy, and childbirth) (Davis-Floyd, 2003). These assumptions were embodied within and rooted in a patriarchal model that shaped the nature of the interactions between doctors and birthing women, reflected within existing power and gender constructions (Connell & Messerschmidt, 2005). However, feminist movements reject the dominant (male) patriarchal assumptions that contextualised women's bodies with a fixed determinate form based on pre-cultural interpretations (Brush, 1998; Cleary, 2016).

In the early 1960s, advancement in obstetric technology, particularly those concerned with foetal monitoring, increased the medicalisation of childbirth. With the 'risk culture' and 'pathologising of childbirth' also came the increasing use of the words 'safe' and 'safety' to justify interventions in birth. Medical professionals defined and measured what was

[12] The second wave focused on issues of discrimination and equality of the sexes as well as achieving a critical consciousness of women's lived experiences that reflected existing sexist power structures.

considered ‘safe’ or conceptualising what ‘safety’ meant for women (Korte & Scaer, 1992). Consequently, second-wave feminist critics of technocratic birth considered women’s use of high-tech obstetric interventions as “false consciousness”[13] and “a violation of their true (essential) nature” (Annandale & Clark, 1996 cited in Beckett, 2005, pg. 259). Thus, claiming that technological interventions are inherently patriarchal. Midwifery was also considered an arm of feminism, and natural birth activists attributed ‘moral superiority with natural/normal birth and midwifery (Beckett, 2005; Campbell & Porter, 1997). However, some third-wave feminist theorists have challenged such rhetoric and philosophical assumptions, such as ‘false consciousness and the claim of “passive socialisation”[14] as factors responsible for women’s interest and use of high-tech obstetric interventions in childbirth. Beckett (2005), for example, viewed the argument as theoretically imbalanced, arguing women’s right of choice in childbirth should not be objectively defined. Rather, the use and experience of obstetric interventions in pregnancy and childbirth be viewed outside the lens of oppression and subordination as a tool for women’s empowerment in their pregnancy and childbirth experience. According to Beckett, “this argument reflects the post-structuralist emphasis on the need to destabilize rather than invert oppressive dualisms, as well as an appreciation for the diversity of women’s experiences and desires” (2005, pg. 263).

The invocation of natural birth as the tenet of ‘good motherhood’ is considered by many to be an essentialist ideology. It reproduces the patriarchal domination and conceals the usefulness

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[13] False consciousness - refers to the Marxist ideology of systematic domination of the consciousness of subordinate/exploited groups, whereby their cognitive representations of social realities conceals and misrepresents the realities of domination, exploitation and subordination, which then prevents members of the group to combine effort and take action for social change. See Eyerman (2016).

[14] Referring to unconscious gender stereotyping, born out of the social influences of inherited cultural norms.

and women's positive experience of obstetric interventions in birth (Beckett, 2005; Malacrida & Boulton, 2012; New Zealand Society of Anaesthetists, 2016; Prochaska, 2015; Tuteur, 2016). The essentialist rhetoric of natural birth's 'moralistic value' and the holistic view of midwifery as the profession of 'superior and empathetic care' remains a problematic concept which assumes women's biologically inherited and socially constructed attributes of empathy and intuition in the construction of midwifery as a profession and midwives as professionals (Barton & Bibas, 2017; Korte & Scaer, 1992). Thus, it is based on the 'essentialism of femininity' without considering possible existing sociocultural conflicts between birthing mothers and midwives (Beckett, 2005).

However, in recent decades, feminist thoughts on maternity have evolved into new conceptualisations that highlight the changing trends in feminist thinking. Whereby there is a "shift from essentialist accounts of mothering to a more liberating poststructuralist awareness of maternal subjectivities as diverse, multifaceted, and shifting" (Jeremiah, 2006, pg. 22). This thinking has informed the philosophical foundations of a relationship between poststructuralist theory and the midwifery model of childbirth. Through its philosophical practice and cohesive framework, modern midwifery has sought to protect women's agency and unique experiences (Campbell & Porter, 1997). They are emphasising autonomy and choice and recognising that women are "embodied subjects" with "propriety rights" over their bodies and unique experiences (Campbell & Porter, 1997; Davies et al., 2011; Gupta & Richters, 2008, pg. 239).

Midwifery-led care infers autonomy for midwives by advocating for the freedom to practice as an independent profession devoid of an intersecting patriarchal influence. Midwives have recognised the importance of understanding and protecting women's experiences and valuing embodied knowledge of pregnancy and childbirth. This experience is uniquely constructed

between the woman and her midwife while continuing to promote the narrative of natural birth (Akrich & Pasveer, 2004; Gupta & Richters, 2008; Macdonald, 2006a; McClean & Mitchell, 2018; Thelin, Lundgren, & Hermansson, 2014; Walsh, 2010) discursively.

The following sections examine the changing perspectives on childbirth and New Zealand's maternity system, focusing on the literature examining health professions. Poststructuralist feminism focuses on women's subjective experiences and recognises the difficulty of seeking common understandings among women due to personal meanings of social reality. Much of the relevant literature is grounded in midwifery. Therefore, it offers critique of the medical model of birth from a poststructuralist lens and how biomedical ideologies have been historically intertwined with gender-based marginalisation.

3.5. Childbirth history in New Zealand

In the 1800s, before the regulation of midwifery, lay midwives assisted women in giving birth in their homes (Papps & Olssen, 1997). With no formal midwifery education or registration available, a relative or a neighbour who had learned the skill of supporting women to give birth through her own experience of childbirth or by attending birth alongside doctors or another experienced handywoman performed the role of the midwife (Donley, 1998; Andrea Gilkison, Giddings, & Smythe, 2013; Papps & Olssen, 1997). Other semi-trained midwives (usually missionaries) also assisted women during and after their birth. As the lay midwife had no formal qualification, her practice and skill established her reputation and the fee she could expect for her services (Papps & Olssen, 1997).

For the Māori and European (Pākehā) communities, there were clear differences in the culture and practice around birth, specifically the environment where the birth occurs, the

support system available, the nature of the birthing process, and length of recovery after birth (Stojanovic, 2010). For example, while home birth was the norm for both Māori and Pākehā women, it was common for European women to give birth in a room within the family house, which was different from traditional Māori birthing culture (Elsdon, 2016). Māori birth typically took place in a specially-constructed shelter which some tribes call a *whare kohanga* (Tupara, 2017). In some traditions, the items used for birth, including the *whare tohanga* are burnt down after every birth. The significance lies in the ascription of childbirth as a sacred event. Thus, the environment where delivery occurs should be kept sacred (Wepa & Te Huia, 2006).

Childbirth from a Māori world view comes with the mātauranga Māori (Māori knowledge) (Panuku, 2008), that through childbirth the continuation of the whānau (family) and the whakapapa (ancestry) is made possible (Wepa & Te Huia, 2006). With this knowledge and the tapu (sacredness) of childbirth comes certain expectations on the 'correct way to birth' and acceptable after-birth practices that reflect the historical and collective tikanga (custom) of Māori (Tuhiwai-Smith, 2000). For example, the expectation on a Māori woman to squat rather than lie on her back, the mirimiri (massage), karakia (incantations), keeping the placenta (whenua) still attached to the child until it detaches naturally, burning of the *whare kohanga* and burying the whenua (placenta) few weeks after the birth were either widespread or followed among some iwi (Tikao, 2012; Wepa & Te Huia, 2006). Many of the practices were lost to colonisation, coupled with the dwindling size of the Māori population caused by disease outbreaks, a high mortality rate among Māori, and increased infertility (Glover & Rosseau, 2007; Wepa & Te Huia, 2006). These practices were inconsistent with the medical model and practice norms that dominated in the early 1900 and caused complications for doctors, hospital midwives, and nurses in their relationship with Māori birthing mothers

(Stevenson, Filoche, Cram, & Lawton, 2016; Tupara, 2017; Tūpara, Ihimaera, & Te Rau Matatini., 2004). By 1907, the enactment of the Tohanga Suppression Act, which sought to abolish all forms of Māori knowledge and skill in child delivery, became a critical contributing factor to the mass directional shift of Māori women from traditional home births to hospital births (Stephens, 2001).

The percentage of women of non-Māori ethnic origin who gave birth in hospitals between 1920 and 1935 increased from 30% to almost 80% (Donley, 1998; 1986). Māori similarly abandoned traditional birthing practices to adopt modern hospital birth (Sweetman, 2013). The claim was that the hospital provided the safest space for childbirth due to technically equipped medical professionals with the necessary skills to offer safe delivery. Gradually, the influence of midwives diminished as more women turned to medical professionals for childbirth (Stojanovic, 2008). By the late 1940s, nearly 50% of Māori births took place within a hospital setting, and by 1960, almost 90% of Māori women births occurred in hospitals (Donley, 1998; Stojanovic, 2010).

With the increasing number of Māori births occurring in hospitals in the 1960s, there became an increased sensitivity to possible obsolescence of Māori birthing practices, culture and values. This concern was instrumental to the formation of a national collective of Māori midwives *Ngā Maia o Aotearoa me Te Waipounamu,* whose practice reaffirms the Māori knowledge and epistemology and consistent with the Māori beliefs (Tūpara et al., 2004). Although colonisation eroded Māori birth culture and practices, some traditional practices are beginning to re-emerge (Pihama, 2004; Stevenson et al., 2016), such as, the use of protective prayers (karakia) before, during, and after birth, the ritual burying of the placenta (whenua) and the giving of traditional Māori names as a form of transference of strength, have been

become common rites observed during Māori birth (Abel, Park, Tipene-Leach, Finau, & Lennan, 2001; Pihama, 2004; Stevenson et al., 2016).

The Māori philosophy of birth holds firmly the need for cultural care and the importance of receiving maternity care from a midwife or care provider who shares a similar cultural orientation for emotional wellbeing, cultural safety, and partnership (Hannagan, 2018). The effect of colonisation on hospital-based maternity care and the ostracisation of traditional Māori birthing culture had a considerable impact on Māori and midwifery practice (Wepa & Te Huia, 2006).

3.6. The medicalisation and hospitalisation of birth in New Zealand

The transformation of birth as a professional practice and midwifery as a regulated profession in New Zealand began the obsolescence of lay midwives. The *Midwives Act* 1904 established state control of midwifery practice by making the registration of midwives a legal requirement and categorising midwives into two classes: A and B (Kent, Stephen, Doris, & Cooper, 1992). Class A consisted of midwives trained in a recognised midwifery training school and had passed the midwifery examination in New Zealand or gained their qualification overseas. Class B was unregistered women practising as handywomen with at least three years of birthing experience and evidence of good character. (Gilkison, Giddings, & Smythe, 2013; Stojanovic, 2008). The enforcement of midwife registration also meant that maternity hospitals became classed. Small maternity hospitals were owned and managed by midwives and doctors, while large hospitals catered to maternity cases where medical problems arose. Then came midwifery training schools and the establishment of core midwifery service vs independent practitioners. Still, many midwives saw these creations as a

means of putting the midwifery practice under the control of medical professionals (Stojanovic, 2008).

The hospitalisation of maternity care was foundational to increased interventions in childbirth in New Zealand (Arthur, Payne, Dixon, Pairman, & Shaw, 2005; Mein-Smith, 1986). The rise of interventionist birth coincided with increased puerperal infections and a rise in maternal mortality rates. Investigations pointed to blood poisoning (puerperal sepsis) in hospitals from contaminated medical equipment used during childbirth as the cause (Pollock, 2018; Stojanovic, 2010). Medical practitioners refused to accept responsibility for the failures and blamed midwives (Mein-Smith, 1986; Stojanovic, 2008). A Special Committee of Enquiry on Maternal Mortality, in turn, began a campaign to address antenatal care, asepsis, hospital policy, and midwifery to reduce the increasing rate of maternal mortality and morbidity. One of the measures introduced was the 'special delivery room', where women in labour, sedated or not, were transported to a 'sterile field' (Stojanovic, 2008, 2012). Maternity units required different sanitary arrangements to curb infections in maternity units. Most midwives who operated private or small maternity units could not afford the additional equipment due to the great depression. With more midwives retiring, strict legislation, and the belief that birthing was dangerous due to the high maternal mortality rate, hospitalised births gradually became the norm (DeVore, 1997). The economic situation was not entirely disadvantageous for the midwives; most women were unable to afford the medical fees of hospitals and returned to midwifery care. Following resistance among doctors, an inquiry committee recommended doctors to be present at all births, providing home care to all women. Hospitalisation of childbirths considered of high risk was to be without cost (Mein-Smith, 1986).

By the late 1930s and early 1940s, the hospitalisation of childbirth had gained prominence over home birth with the use of anaesthesia and asepsis, which did not necessarily take away

women's pain but its memory (Papps & Olssen, 1997). Childbirth was aided by a cocktail of prescription drugs, requiring intense observation and monitoring lest the woman dies in her sleep. These drugs sedated the mother and left her without the energy to obey her body's instinct to push, so forceps birth became familiar with adverse effects on the child (Papps & Olssen, 1997). The drugs reportedly sedated the child, and, as a result, more children were resuscitated at birth. There was also the disadvantage of cross infections, exposure to hospital pathogens, and puerperal diseases due to vaginal examinations and instrumental births (Papps & Olssen, 1997). By the 1950s, hospitalised deliveries occurred in a maternity unit similar to an operating theatre, with the mother's legs held in stirrups while she lay horizontally. Mein Smith argued that the process was degrading and frightening for the woman as the clinical approach failed to understand childbearing as an emotional experience (Mein-Smith, 1986). These were done in the interest of the mother and child to reduce unnecessary deaths. With the wane in sepsis deaths and the successful lobbying of the Obstetrical Society to endorse hospitalised birth, there was an inevitable shift in power favouring medical practitioners. Caesarean section became more acceptable, and the medicalisation and hospitalisation of birth became even more politically powerful (Mein-Smith, 1986).

A lack of organisational structure and small numbers meant that midwives were ineffective in preventing changes to the practice. The medicalisation of birth saw the introduction of nursing culture into midwifery and the creation of the nurse-midwife. Arguably, it intensified the medicalisation and hospitalisation of childbirth and nursification[15] of midwifery (Stojanovic, 2008). The *Nurses Act 1971* consolidated and amended the Nurses and Midwives Act 1945, which included the discipline of midwifery. Midwifery courses were

[15] The association of nursing theory and practice with midwifery (Mortimer-Jones & Fetherston, 2018).

integrated into advanced nursing qualifications to promote nursification, and were available only to registered nurses (Gilkison, Pairman, McAra-Couper, Kensington, & James, 2016). The new legislature meant that virtually all childbirth was carried out in the hospital by nurses and physicians. The new act arguably removed the responsibility of supporting childbearing women and overseeing the progression of delivery from midwives, creating a dent in midwives' knowledge and confidence in providing birthing services to women outside the hospital and resulting in the loss of autonomy. Consequently, the hospitalisation and professionalisation of childbirth irrevocably changed midwifery maternity services.

While the Committee of Inquiry into Maternity Services sought to humanise hospital birth and strongly condemn homebirth, more feminist movements sprung up from the 1960s (Stojanovic, 2008). In perceived solidarity and rebellion against the technological takeover of their bodies, more women shunned hospitalisation and opted for a home birth (Gilkison et al., 2016). This action was in direct opposition to the closing down of small maternity centres, and feminist organisations such as Save the Midwives and Maternity Action supported the new trend (Donley, 1998). Several legislative and regulatory measures were put in place to minimise the pressure resulting from the feminist movement and curb the challenges of the iatrogenic effect and the rise in instrumental births. By 1989, the New Zealand College of Midwives (NZCOM) was formed and led the first significant change to midwifery. By 1990, the *Nurses Amendment Act* was passed after pressure from midwifery organisations and women's group. The new act is credited to have returned autonomy to midwives in New Zealand, allowing for community midwifery practice and individualised continuity of care for New Zealand women (Stojanovic, 2008, 2010). Today, the NZCOM represents about 90% of practising midwives in New Zealand and provides continuous education and advice to midwives, maternity consumers (women and their families), district health boards, the

ministry of health and other workforce unions on matters concerning midwifery best practices.

3.7. Critical views of the biomedical/obstetric-led model

Childbirth has increasingly evolved into a medicalised phenomenon. Today, most women are exposed to a milieu of medical interventions from pregnancy through birth, which usually takes place in the hospital (Jansen, Gibson, Bowles, & Leach, 2013a). In the early 1970s, social science literature was increasingly viewing medicalisation as a tool of social control and power, underlining a problematic or negative meaning to the term (Zola, 1971). The routine medicalisation of birth transferred control of the reproductive process to medical professionals and circumvented midwives' roles (Johnson, 2008). Neiterman (2013) argued that medicalisation alienates women from their bodies, rendering them passive beneficiaries of maternity care. Davis & Walker (2010) believed that medicalised conceptions of the body have shaped the embodiment of pregnancy and childbirth and turned women's bodies into 'medical gaze' objects. However, the medical scrutiny is on the assurance of safety for a woman and her unborn child through continuous 'gazing' within a technologically-equipped hospital space. Therefore, medical interventionists believed that risk management and safety of a mother and her child is enough justification for medical intervention in pregnancy and childbirth (Bryers & Van-Teijlingen, 2010; Lothian, 2012).

Section 2.0 acknowledged that feminist scholars have remained critical of the routine medicalisation of childbirth that transfers the control of the reproductive process of birth to medical professionals. Neiterman (2013) posits that this transfer alienates women and separate them from their bodies, making women passive beneficiaries of maternity care. In

his view, medicalised conceptions of the body have shaped the embodiment of pregnancy and childbirth and women's postpartum experiences, transforming women's bodies into objects of 'medical gaze'. Medicalisation also enforces the domination of the medical profession over women's decision-making around childbirth. The assumption that women are incapable of giving birth without medical/obstetric intervention considers women's bodies "inherently problematic and potentially dangerous" (Macdonald, 2006, pg. 236). The routine use of obstetric interventions in childbirth without clear and consistent indications alter childbirth from a 'normal', family-centric physiological event into a medical phenomenon with its own inherent risk (Kukura, 2016). Thus, midwives' roles in childbirth are eroded, and the midwifery philosophy of pregnancy and childbirth as a normal and natural process threatened (Brodrick, 2008; Davis & Walker, 2010; Parry, 2008). Midwives have, however, argued that since physicians train to manage and treat illnesses and abnormalities, their role in pregnancy and childbirth should focus on high-risk cases where their expertise is required (Davis & Walker, 2011). Besides, about 85% of women in New Zealand experience 'normal' uncomplicated pregnancy and childbirth which do not require medical intervention (Davis & Walker, 2011; Ministry of Health, 2017)

Interestingly, WHO reports a 1 in 37 chance of a woman dying from pregnancy and childbirth-related complications in developing nations compared to 1 in 7800 in most developed countries (WHO, 2019). The disparity is due to the availability of obstetric care in the developed regions, which also argues the importance of a highly trained healthcare workforce and accessibility to specialist obstetric services (Baker, Bellows, Bach, & Warren, 2017; WHO, 2011; 2019). Caesarean section, assisted delivery by forceps or ventouse cup, episiotomy, artificial rupture of membranes, and epidural anaesthesia are among the most commonly used obstetric interventions during childbirth (Jansen et al., 2013a). One can argue

that the medicalisation of birth has proactively ensured the safety of childbearing women and their infants by ensuring that obstetric risk situations during pregnancy and childbirth are properly managed.

Today, childbirth is safer than any other time in history (WHO, 2015a), and women have access to adequate pain relief, including epidural anaesthesia (Thomson, Feeley, Moran, Downe, & Oladapo, 2019). Also, maternal deaths have declined due to obstetric interventions such as caesarean section, and more than any time in history, women are more aware of their choices in maternity care (Arthur & Payne, 2005; Hull, Bedwell, & Lavender, 2011).

3.8. The midwifery-led model and continuity of care

The midwifery-led model of care hinges on the premise that childbearing is a normal and natural phenomenon. As such, the experience should be with little or no routine intervention (Sandall et al., 2009). Though modern medicine can manage and reduce potential risk in childbirth, it is also capable of transforming childbirth from a blissful experience for the woman into an experience of obstetric trauma (Gamble & Creedy, 2005; Muraca et al., 2018; Reed, Sharman, & Inglis, 2017; Somera et al., 2010).

This midwifery-led model promotes continuity of care and, in NZ, is dominated by a primary carer model, which sees the majority of care provided by a self-employed midwife (Haggerty et al., 2003). This midwife provides continuity of care from pre-conception to six weeks post-partum (Foureur et al., 2009; Davis & Walker, 2011). In NZ, Community midwives often work independently, though in collaboration with other health professionals when and where necessary. Core midwives are employed by District Health Boards (DHBs) to provide 24 hours rostered-shift cover within the different maternity units in the DHB and the tertiary

hospital (New Zealand College of Midwives, 2015). With the current evidence-informed knowledge of their midwife, women are encouraged to engage in independent and collaborative decision-making to determine what is best for them and their child and gain confidence throughout the process of childbearing.

Continuous support for childbearing women by a specific caregiver or a small group of caregivers from the onset of pregnancy, during labour and postnatally, is recognised in the literature to promote positive birth experience and optimal maternal outcomes (Forster et al., 2016; Perdok et al., 2018). There are three types of continuity of care identified in the literature, namely; management continuity (communication of facts and judgement between team, institution, and professionals and between professionals and patients), informational continuity (time availability of relevant patient-related information), and relational continuity (establishing relations based on reciprocity and trust) (Foureur et al., 2009). Relational continuity has been the focus of new models of care and is perceived to have the most significant impact on experiences and outcomes of care (Foureur et al., 2009). Haggerty et al. (2007, pg. 340) provide an operational definition of relational continuity as "a therapeutic relationship between a patient and one or more providers that spans various healthcare events and results in an accumulated knowledge of the patient and care consistent with the patient's needs." This definition characterises the distinctive model of a patient-provider relationship, which is central to primary health care practice irrespective of organisational structure and speaks to the midwifery philosophy of continuous partnership and non-authoritarian personalised care (Baker et al., 2005; Haggerty et al., 2011, 2003). Research has shown an association between patients seeing a single health provider for multiple health issues over a long period of time and the experience of positive care outcomes, including fewer emergency admissions (Burge, Lawson, & Johnston, 2003; Kao & Wu, 2017; Kohnke & Zielinski, 2017;

Wasson, 1984), increased uptake of preventive services (Flocke, Stange, & Zyzanski, 2019; Kim, Kim, Choi, Hwang, & Kim, 2012; O'Connor, Desai, Rush, & Cherney, 1998; O'Malley, Mandelblatt, Gold, & Cagney, 1997), fostering of patient-provider trust and patient adherence to medical advice (Arnold, McGilvray, Kyle Cooper, & James, 2017; Berry et al., 2008), increased knowledge, better clinical situational awareness and improved patient-provider communication (Bertakis & Callahan, 1992), improved cost-effectiveness (Hollander & Kadlec, 2015; Raddish, Horn, & Sharkey, 1999; Sveréus, Larsson, & Rehnberg, 2017), reduction in delay-related risk tendencies (Hanafi et al., 2015) and higher emotional support and patient satisfaction (Devoe, Tillotson, Wallace, Lesko, & Angier, 2012; Linn et al., 1985).

The concept of partnership was crucial to developing the case-load model of midwifery care and foundational to the idea of continuity of care (Guilliland & Pairman, 2010). In New Zealand, a partnership relationship between the woman and her midwife forms the philosophy of midwifery care (Pairman & McAra-Couper, 2015). Partnership is the "relationship of 'sharing' between the woman and the midwife, involving trust, shared control and responsibility and shared meaning through mutual understanding" (Guilliland and Pairman, 1995: pg. 7). 'Partnership' is the language midwives use to refer to their relationship with the client. It represents the contextual, ethical, and legal premise for the provision of midwifery-led care (Kenney, 2011).

Midwifery care promotes relational continuity through flexible and anticipatory care, which supports and protects women's reproductive rights, provide adequate and timely information, and supports participatory care and informed decision-making for women (Fahy, 2012; Marshall, Spiby, & McCormick, 2015; Soltani & Sandall, 2012). Yet, the debate around midwife-led care and adverse neonatal outcomes persist. A current study in New Zealand

revealed that babies are more at risk during birth when a midwife rather than a GP lead carer is in charge (Wernham et al., 2016). The findings of this research have raised conflicting opinions among different care providers and policy analysts. In some ways, it reignited the historic professional tension between doctors and midwives, elaborated on in section 2.7. It is increasingly difficult to disregard the potential health problems with midwifery-led maternity care. The evidence also shows that maternal and neonatal mortality rates within midwife-led and obstetric-led care remain similar. Overall, adverse health outcomes remain low in New Zealand compared to other developed countries. The findings also do not undermine the many benefits of midwife-led care, especially concerning patient satisfaction and lower intervention rates (Grigg & Tracy, 2013; Iida, Horiuchi, & Nagamori, 2014; McAra-Couper et al., 2014; Miller, Mason, & Jaye, 2013; Wernham, Gurney, Stanley, Ellison-Loschmann, Sarfati, et al., 2016).

3.8.1. Midwifery and the evolution of a profession

A midwife assist a woman and her family in normal childbirth. The midwife's role has historically evolved both within the context of the changing maternity system and the needs of maternity consumers over time (DeJoy et al., 2015). The international confederation of midwives (ICM) (2017) represents midwives globally and works to strengthen professional associations of midwives throughout the world. The ICIM (2017, np.) conceptualises the midwife's role in providing care to women and promoting normality in childbirth within an integrated system of maternity care:

> The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care, and advice during pregnancy,

> labour, and the postpartum period, to conduct births on the midwife's own responsibility, and to provide care for the new-born and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance, and the carrying out of emergency measures. (ICIM, 2017, np.)

In New Zealand, the midwifery profession is self-regulated via the New Zealand College of Midwives (NZCOM) and the Midwife Council of New Zealand (MCNZ). NZCOM was established in 1989 and led the first significant change in midwifery. It provides education and advice to midwives, maternity consumers (women and their families), district health boards, the Ministry of Health, and other workforce unions on midwifery best practices (Sweetman, 2013). MCNZ defines the minimum standards required for the registration and midwifery practice in New Zealand. They certify and audit midwifery and midwife practices and services to women and families to ensure that they meet the best professional standards (Sweetman, 2013).

The New Zealand College of Midwives identify the key concepts that define the distinct role of midwives in promoting the health of women, newborns and their families as a partnership; respect for human right and dignity, cultural sensitivity, advocacy for a woman's right to free and informed choice. Focus on health promotion and disease prevention that views pregnancy as a normal physiological event (Freeman, Timperley, & Adair, 2004; New Zealand College of Midwives, 2015). Good midwifery practice is centred on individualised care and respect for dignity, multidisciplinary work, and promotion of health, high standards of practice and care, being open and honest with integrity, and upholding the reputation of the profession (Nursing & Midwifery Council, 2019; Nursing and Midwifery Board of Australia (NMBA), 2018).

As mentioned in the previous section, increasing rates of medicalised birth pose a significant challenge to the midwife's role in childbirth (Mander, 2007). Some midwives are responding to this perception by increasingly focusing their role as midwives on promoting normal birth. Others bridge the disciplinary divide within the maternity care systems by grounding their approach to childbearing firmly within a multidisciplinary maternity team (Warwick, 2001). Drawing from the midwifery concept of 'being with women', many midwives continue to provide care to their clients regardless of whether their birth experience is considered normal or abnormal. Thus, suggesting a notion of a false dichotomy between normal and abnormal in birth discourses (Davis & Walker, 2011).

Normal childbirth within the midwifery framework is conceptualised as physiological, spontaneous labour and delivery without medical interventions and characterised by minimal mother-infant separation (Young, 2009). In practice, this will occur at home or a free-standing primary birth centre. However, in most Western countries such as New Zealand, over 80% of childbirth occur in hospitals (Ministry of Health., 2016; Ministry of Health, 2015b). WHO (1997, pg, 1) noted that "the concept of normality in labour and delivery is not standardised or universal", which suggest existing fluidity in the concept and meaning that the components used in describing 'normality' in childbirth may be unusual and lacking philosophical clarity (Mander, 2007; WHO, 1997). Gould argued that incorporating some interventions during delivery, though clinical, is considered by some midwives as 'normal', demonstrating how contentious the definition of 'normality is, even among midwives (Gould, 2000). Green (2006), cited in Page and Mander (2014), argued that the concept of normal birth is defined by medical parameters, hence its ambiguity in a midwifery-led framework. Though the midwifery philosophy hinges on minimal or no medical intervention, current records have shown an increase in the rates of operative deliveries in New Zealand,

comparable to other developed countries (Jansen, Gibson, Bowles, & Leach, 2013b; Ministry of Health, 2017; Wiegers, 2003). Besides, midwives recognise the importance of supporting women to receive obstetric care in high-risk obstetric conditions. It supports women to exercise their right of choice and place of birth and strives to meet the woman's individual needs while promoting a relationship of mutual trust and partnership. Therefore, the term 'normal' is used with caution in this study, and when used, it denotes a 'natural birth', rather than an 'ideal birth' as represented in most midwifery literature.

3.9. The concept of risk in medicine

Risk perception and risk management are identified as essential factors in the rising rate of interventions in childbirth (Lennon, 2016). Interventions such as the use of epidural, oxytocin, electronic fetal monitoring (EFM), catheterisation, and intravenous infusions are routine in childbirth despite the increasing concern of their overutilisation and the direct relationship to the global rise in CS rates (Lennon, 2016; Regan & McElroy, 2013). Many feminist scholars have argued that 'risk' is a construction of the medical profession and deployed as a means to maintain power, limit women's voices and control the scope of practice of midwives and therefore increase the need for medical supervision and obstetric interventions (Mitchell & McClean, 2014). Yet, the goal of risk management in pregnancy and childbirth is to improve patient safety and the quality of care despite increasing concerns of the impact of the rising rates of obstetric interventions in women's experiences of maternity care (Rattray, Flowers, Miles, & Clarke, 2011).

Midwives report leading care from the paradigm of normality. However, recent research shows that the absence of adverse events (abnormality) is the basis upon which midwives

perceive ‘normal’ childbirth (Healy et al., 2017). Increasing abnormality is indicated through technology and surveillance (Scamell, 2011); as midwifery is concerned with normal birth, heavy reliance on technology and medical intervention to ascertain risk directly contrasts midwifery ideology and practice (Healy et al., 2017). Page and Mander (2014) reported that midwives do not view childbirth as “black and white” or predictable. Instead, they face “uncertainties” when caring for their clients. Ensuring that they make the right decisions in their client’s care means that sometimes midwives dismiss the generalised concepts of their philosophy of promoting normality and introducing interventions or referring them for other obstetric care. Healy believes that midwives “sometimes over refer” women to obstetricians on the perception of risk as a means for reassurance from doctors, eschewing responsibility for decision-making if something goes wrong (Healy et al., 2017, pg. 371). By doing this, midwives may be deferring their professional autonomy to physicians on the grounds of safety, which could be considered an effort to minimise professional risk. This view is in contrast to the suggestion that in midwifery practice, the concept of safety is secondary to achieving normality in childbirth (Larsson, Aldegarmann, & Aarts, 2009).

3.10. Current Midwifery and Obstetric Occupations: Lead Maternity Carer Model

Since the early nineteenth century, the New Zealand maternity system has taken different forms, transformed by the Midwives Act of 1904 and the Nurses Amendment Act of 1990. The various statutes have not been without challenges and calls for changes from within and outside the midwifery profession.

Before 1990, general practitioners were the primary care providers for nearly 50% of birth. The Lead Maternity Carer (LMC) model, introduced in 1996 and enshrined in section 88 (Primary Maternity Services Notice, 2007) of the New Zealand Public Health and Disability

Act 2000 (Ministry of Health, 2007a), introduced a new funding scheme for maternity care in New Zealand (Ministry of Health, 2012, 2014, 2015b). Under this model, expectant mothers within New Zealand register and select a Lead Maternity Carer [a midwife, specialist obstetrician or general practitioner obstetrician (GPO)]. The carer has both budgetary and clinical responsibility with the management and care provision for their client during pregnancy, labour and up to 6 weeks after birth (Miller et al., 2013; Ministry of Health, 2015; Smythe et al., 2016).

A lead maternity carer can employ the service of another LMC as a backup should a need arise. The backup LMC is funded from the fixed budgetary allocation of the maternity user; midwives and GPs can provide shared antenatal, intrapartum, and postnatal care to a woman the lead carer and funding the other allocated budget. Thus, the LMC midwife stands to lose money in the current funding system when the woman's care is transferred to the GP or an obstetric specialist, which may disincentivise inter-professional collaborative care (Miller et al., 2013). Though, in some cases, the obstetrician is consulted.

Women who cannot receive primary maternity services from an LMC, either by choice or due to unavailability, can still receive such services from their district health board (Ministry of Health, 2015b). The legislative changes and lifestyle concerns among GPs meant that the involvement of General Practitioners as LMCs significantly decreased over time, and by 2007, only about 5% of women registered with a general practitioner due to the unprofitability of new funding arrangements (Miller et al., 2013). Though GPs argue they provide more excellent continuity of care as they look after the babies and women after the post-natal period and usually before. Funding was considerably more favourable for midwives who provide supportive companionship and continuity of care for the childbearing woman and currently deliver care to nearly 94% of birthing women in New Zealand

(Ministry of Health, 2015b). These changes increase accountability, reduce escalating health expenditure, and increase efficiency (Exton, 2008; Ministry of Health, 2015b; Quin, 2009). However, the withdrawal of general practitioners from acting as LMCs has resulted in a limited choice of maternity care providers for women (New Zealand Medical Association (NZMA), 2006). The NZMA (2006), speaking on the relevance of the Notice in the provision of maternity services, noted that the current system isolates maternity practitioners in their roles and remains relatively incompatible with the current general practice system in New Zealand. Also, they have a considerable impact on the overall participation of general practitioners within the maternity care system:

> *The basis of the Notice as a funder-to-individual provider arrangement has little relevance in the contractual capitation environment in which they provide other general practice services. (NZMA, 2006, pg. 1)*

The arrangement appears in conflict with the vision and provisions of primary health care delivery within the context of GP practice according to NZMA. Therefore, it argues for a more flexible approach that promotes local adaptability and encourages GP participation in primary maternity care services.

According to the 2017 *Report on Maternity*, midwives (94.2%) represent the highest number of practitioners who currently provide lead maternity care for women in New Zealand, with obstetricians and GPs 5.6% and 0.2%, respectively. The percentage of women who register with an LMC varies with regions, age, ethnic nationality, neighbourhood deprivation, and gravidity, indicating an association between social determinants of health and women's access and registration with a lead carer. Women giving birth for the first time are most likely (99.3%) to register with an LMC compared to those who had given birth before (97.2%). The same applies to women of European ethnic nationality and Māori women with Pacific women less likely to register (Ministry of Health, 2017). Also, women from most deprived

neighbourhoods (86.2%) are less likely to book with an LMC than women from well-off areas (94%). The workforce's availability may account for the differences in registration with an LMC among the listed categories (Ministry of Health, 2017).

The New Zealand College of Midwives (NZCOM) reported that between November 2017 and January 2018, over a thousand women in the country (especially in Auckland and Waikato) gave birth without an LMC midwife or obstetrician. In Canterbury, for example, around 140 women were unable to find a midwife LMC in December of 2018 (Meier, 2018). Reports of fatigue and burnout among midwives are recorded in academic literature and the mainstream media (Dixon et al., 2017). Caseload midwives work long hours each day. The fixed budgeting system means that the providers do not receive extra remuneration regardless of the time spent working or if the care is provided during weekends or public holidays. Karen Guilliland, the chief executive of the New Zealand College of Midwives (NZCOM) described the situation as a "service in crisis", noting years of chronic underfunding as a key factor (Meier, 2018, n.p).

Among other measures in 2017, the New Zealand government added the midwifery profession to the 'immediate skill shortage list' to review the maternity workforce in the country (Health Central NZ, 2017). The government agreed to a 2.5% ($2.8million) pay increase for self-employed midwives in the same year. However, midwives working in the system continue to push for better remuneration and working conditions. NZCOM advocates for a new funding scheme that ensures a fair and proportional payment structure for LMCs. Priority is given to childbirth and maternity care in health budgeting (NZCOM, 2017). With the growing NZ population, there is also a shortage of obstetricians and doctors in the country. Out of the 32 OECD countries, New Zealand has the sixth-lowest number of specialists per head of population, though it ranks 25th of 35 in the number of surgical

operations per 100,000 population (Association of Salaried Medical Specialists, 2015; Keegan, Saw, DeLoyde, & Young, 2015). The attrition rate for specialist doctors is also on the rise, and the number of specialists lost to other countries continues to grow. The implication is that more inadequate long-term access to public services increases wait times, higher workloads, and burnout of practitioners, with potential impact on the quality of care delivery (Chambers et al., 2016; Powell, Stubbs, Hughes, Woods, & Lamb, 2010).

3.11. Professional tension/evolution

The *Midwives Act 1904* was arguably a double-edged sword. While the enactment gave legal status to the midwifery profession and established both a midwifery registry and several training institutions for midwives, it also gave a significant amount of control of maternity care to medical professionals. In addition, midwifery training institutions were located within hospital settings (Chick et al., 1997; Andrea Gilkison et al., 2013; Stojanovic, 2010).

Today, the importance of multidisciplinary collaboration in the improvement of maternity care services cannot be overemphasised. However, interprofessional ideological tensions between clinicians and midwives exist in many settings (Behruzi, Klam, Dehertog, Jimenez, & Hatem, 2017). Maternity care goals are best met when care is delivered within a collaborative, inclusive, and integrated partnership-based model of woman-centred care (Hoope-Bender et al., 2016; National Health Service, 2010).

Collaborative maternity care for women, involving both a midwife and a clinician, especially in a case of complicated or high-risk pregnancy, is reported to improve women's choices and access to quality maternity care (Behruzi et al., 2017; Coxon, Homer, Bisits, Sandall, & Bick, 2016; Reiger & Lane, 2009). Collaboration is affected by professional tension or lack of

clarity of role responsibilities (Watkins, Nagle, Kent, & Hutchinson, 2017). For example, Fieldwick et al. (2014) identified a lack of collaboration between midwives and obstetric communities in New Zealand as a bane to adherence to governmental referral guidelines and recommendations regarding management of excess maternal gestational weight gain (GWG). It increases maternal and neonatal risks and contributes to expanded records of gestational diabetes, pre-eclampsia, maternal and childhood obesity (Fieldwick et al., 2014). While achieving inter-professional collaboration in maternity care is an important goal for maternity care systems, it has proved difficult (Behruzi et al., 2017).

In highlighting the importance of clear professional roles, Watkins et al. (2017) foreshadow a central tension between midwives and obstetricians: restricting what constitutes a normal birth. As the medical profession so precisely defines abnormality, midwives have failed to define the concept of 'normality' (Boyle, 2011; Gould, 2000).

The circumstances in which LMC midwives should consult an obstetrician are detailed in Section 88 of the Public Health and Disability Act, providing a precis for care that is no longer considered routine and thus the responsibility of an obstetrician. Interprofessional communication between midwives and doctors is pivotal in the delivery of safe maternity care. In New Zealand, like in other comparable systems, the referral of women from community midwifery care to secondary obstetric care provided an opportunity for interprofessional collaboration and shared responsibility at the primary-secondary interface (Cassie, 2019; Janssen et al., 2020). However, the power imbalance in the midwife-obstetrician relationship favours obstetricians and differing professional philosophies and lack of effective communication hinders collaboration (Cassie, 2019). Besides, current records indicate increased perceptions of risk among childbearing women, with high rates of operative deliveries in New Zealand, comparable to other developed countries (Ministry of

Health, 2017; OECD, 2017), which contribute to much of the professional tension between midwives and obstetricians (Jansen et al., 2013b; Wiegers, 2003). Midwives see their practice contending with the "tensions of uncertainty" of technological and structural systems. Where risk management threatens their individualised and professional attributes of conscious and skilful practice (Healy, Humphreys, & Kennedy, 2016a; Skinner & Maude, 2015, pg. 35).

Three core elements characterise the safety of any model of care; the quality of the model, attitude, knowledge, and skills of the practitioners, and the extent to which the practitioners are integrated and supported by the broader culture of the maternity services (Brasaitė, Kaunonen, Martinkėnas, Mockienė, & Suominen, 2016; Liberati et al., 2019). In a rapidly changing maternity system characterised by a multi-ethnic population with diverse socio-demographic conditions, meeting future maternity needs of women would require new approaches within an integrated maternity health service, characterised by less defined systems/professional structures and philosophical fences (National Health Service, 2010).

Summary

This chapter began with a discussion of how caesarean section is subjectively constructed among different groups. It described how the nuances of choice and autonomy embodied within social change and gender socialisation had rendered surgical interventions in birth a welcomed concept of modern childbirth. Consequently, it has become more attractive to maternity users and providers. By taking cues from the feminist movement and the debates on inequality between men and women, the next part of the chapter looked at the role of male dominance and power in driving a gender-based, politically motivated, and socially constructed conception of womanhood. It also captured the feminist argument on patriarchy

and the scrutiny over women's bodies as objects of the medical gaze. Further, I discussed the internal conflicts and contradictions of the feminist movement and the gap left by the controversies surrounding issues such as the essentialist ideology, conceptualisation of gender identity, women's characteristics, and experiences. New wave feminism and poststructuralist feminist perspectives provided grounds for the critique of feminist theory/literature on gender and women's experiences by focusing on gender and power issues and the role of language and discourse in the construction of meaning and reality. Poststructuralism provided a theoretical framework for further reviewing the historical and professional literature on childbirth and the New Zealand maternity system. It also laid the ground for discussing medicalisation and hospitalisation of birth and the historical and modern views of medical interventions such as caesarean section in childbirth, both from a New Zealand and global perspective.

The literature review highlights the complexity of an unplanned CS as more than a medical phenomenon but an event in the life of the mother that is shaped by biological, psychological, social, cultural, professional, and organisational forces (Behjati-Ardakani, Navabakhsh, & Hosseini, 2017; McAra-Couper et al., 2012; Panazzolo et al., 2011; Roberts, 1992). The understanding of this complexity was an underexplored territory. The extensive investigation further revealed that this was an area less explored from a non-midwifery and medical perspective. This research, therefore, addresses the gap in the literature in terms of women's experience of unplanned caesarean section beyond the operating room and how women make sense of the social complexity of an unplanned and emergency caesarean birth.

The next chapter discusses the methodology adopted for the current study.

Chapter Four: Methodological Framework and Methods

4.0. Introduction

This chapter discusses the methodological framework and the research method for the study. The chapter begins with an outline of the philosophical orientation, which informs the researcher's understanding of assumptions of reality and how this influences the decisions around theoretical grounding and research design. Further presented is an explanation of the qualitative approach and rationale for using the method. Also, the chapter describes the participants' recruitment, data collection, ethical considerations, and issues relating to reflexivity. The researcher's positionality and data trustworthiness is addressed. Finally, the chapter discusses the framework method and a thematic-discourse analysis technique adopted for the data analysis.

4.1. Philosophical concept: Onto-epistemological framework

Social science presents different ways of looking at social reality and the corresponding ways of interpreting it. In approaching conceptions of social reality, we can examine the implicit and explicit assumptions that underpin the different views of our social world (Cohen, Manion, & Morrison, 2013). Burrell & Morgan (1979) identified that there are assumptions of the ontological and epistemological kind which concern (1) the essence and nature of the phenomenon being studied [ontology], and (2) the bases of the knowledge sought; its forms, and how it can be obtained and communicated [epistemology] (Cohen et al., 2013). In investigating a social phenomenon, the inclination of a researcher towards their subject of inquiry is shaped by the implicit ontological and epistemological positions of the researcher's

personal beliefs and philosophy. These positions inform the theory and methodological approach the researcher adopts for their inquiry. Before we can pose ontological questions in social research, we must first make our substantive presumptions of the issue (Searle, 1995).

Ontology relates to the nature of reality and being (philosophical and scientific theory of essence or existence). It primarily informs the question of what exists in the elementary structure of the social world. In other words, it is concerned with the inquest of what is real or true and the conditions of its existence (Dillon & Wals, 2006; Ramey & Grubb, 2009). The ontological conception of social reality is framed within two paradigms or philosophical standpoints: (1) *realism* - the existence of an external reality, a 'truth' that can be identified and proven which is external to social actors, and (2) *relativism* - the view that 'reality' or 'truth' is socially constructed and depends on the perceptions and actions of social actors (Burr, 2005; Burrell & Morgan, 1979; Cohen et al., 2013; Crotty, 1998; Hamlyn, 2005). The ontological framework of the current study resides in a relativist paradigm. Relativist ideology holds that there is no absolute or universal objective truth. Instead, truth is relative to the individual (Burrell & Morgan, 1979; Cohen et al., 2013). It espouses its ethical view on individual considerations, such as personal moral philosophy and emotions and individual values and idiosyncrasy, rejecting the view of universal morality (Singh & Forsyth, 1989).

4.2. Epistemological stance – subjectivism and constructionism

In contrast to ontology, epistemology is concerned with "the nature of knowledge, its possibility, scope, and general basis" (Hamlyn, 2005; pg. 242). It deals with providing a philosophical underpinning to the kind of knowledge we consider possible and how this knowledge can be made legitimate and adequate (Crotty, 1998). Social constructionism was

adopted as the epistemological stance conceptualizing the current study.

Constructionism is an essential model of understanding how knowledge, values, and meanings are produced, predicated upon the dynamics of social interactions between different social actors (Andrews, 2012; Galbin, 1996; Patton, 2015; Segre, 2016). Constructionism rejects the positivist notion of objective reality and truth. Instead, it views reality and truth as diverse and multiple. As a central tenet, constructionism views the experience of reality as historically, culturally, and socially relative (Burr, 2005; Gergen, 2015). Unlike constructivism, which focuses exclusively on the individual cognitive construction of reality, constructionism views reality as a construct of interactions co-constructed between people, societies, and cultures (Patton, 2015; Walker, 2000). Crotty (1998) identifies that in our first view of the world in its meaningful fashion, our culture bestows on us the lens through which we view it. The ways individuals interact and interpret social actions and in-actions over time can create and maintain their socio-cultural perspectives of reality (Toit, Campus, & Way, 2007). Therefore, time, culture, and the social processes that we are exposed to frame our understanding of events. Also, all meaningful realities and categories such as ethnicity, gender, sexual orientation, and social class are socially constructed and may vary according to time and culture (Burr, 2005).

The second premise of social constructionism is that people's knowledge and experiences both of themselves and the world around them are products of social processes (Andrews, 2012; Burr, 2005; Galbin, 1996). Through interaction with one another, members of a particular culture construct customs, values, beliefs, laws, and institutions that make up their social realities (Burr, 2005), which are produced through language (Gergen, 2015). Language, according to Bulcaen (1995), is a constitutive and interactive process

Constructionist research is subjective, relative, and transactional and sees knowledge produced or created through the interactions of investigators and respondents. Knowledge, according to constructionists, does not exist as an external reality, independent of social actors. A positivist would explain and describe a singular reality or universal explanation of situations by identifying causal mechanisms. In contrast, a constructionist seek to explore different understandings of people's experiences and definitions of phenomena through qualitative inquiry. In this way, constructionists' concept of multiple realities is honoured (Galbin, 1996; Patton, 2015; Segre, 2016). People have a wide range of looking at the same thing; this can be from a static view to a more fluid, flexible, and dynamic lens. The researcher rejects the objectivist idea that meaningful reality exists without a mind and instead adopts the belief that there is no objective reality or truth. Interactions with the realities in our world bring truth into existence (Goldkuhl, 2012).

Considering the diversities in women's birth experiences and knowing that individuals can construct the same phenomenon in different ways and with different meanings, the emphasis of the study is on the subjective individual experiences of women of their caesarean birth and their interpretation of those experiences. My epistemological standpoint reiterates the conception that women's experiences are diverse and socially situated. Therefore, methods that historically homogenised women's experiences fail to appreciate their subjective lived experiences (Oakley, 1993).

Birth is socially and culturally constructed. What it means, how it ought to proceed, what is 'preferable', 'ideal', 'natural', and how it relates to the woman are subject to individual interpretation. Women often change their perception of birth over time; what women know (or their knowledge/reality) of childbirth draws from their experience and their perceptions influenced by social actors and social realities (Baston, 2006). In other words, we can argue

that a woman's knowledge of what it means to be a mother before they gave birth changes with experience of childbirth and their transitioning to motherhood, which can form a new perception of the reality of birth.

Women have individual constructions of their birth experiences and are exposed to professional constructions (in their maternity journey), which also emerge from wider societal, cultural, and discipline-specific constructions. It is this understanding that informed the philosophical framework of this study. Therefore, there are two threads to the epistemology of the current research – subjectivism and constructionism. The emphasis on experience as a valid form of knowledge relates to the subjectivism element. On the other hand, the expectations and influences relate to the constructionist element.

4.3. Research design – a qualitative approach

Previous studies have explored issues around CS using different methodological approaches, notably; qualitative (Douché & Carryer, 2011; Fenwick et al., 2003; Gomes et al., 1999), quantitative (Dodd, Pearce, & Crowther, 2004) research designs, and systematic reviews (Bayrampour & Heaman, 2010; Mazzoni et al., 2011). Qualitative studies are used to explore issues around primary care delivery, healthcare providers-patients relationships, interventions around care provision, and improvement strategies for healthcare service delivery (Bradley, Curry, & Devers, 2007). Qualitative approaches are well suited for exploring phenomena within their context, understanding the links between perceptions and behaviours, and creating and refining theories (Bradley et al., 2007). In general, qualitative methods are ideal for in-depth exploration of detailed and rich information in understanding the experiences, attitudes, perceptions, feelings, behaviours and views of people about a phenomenon (Becker,

Bryman, & Ferguson, 2012; Hazzan & Nutov, 2014; Majid, Othman, Mohamad, Lim, & Yusof, 2018; Silverman, 1993).

In recent decades, qualitative methods in health research and particularly in the analysis of maternity care systems have increased (Ward, Furber, Tierney, & Swallow, 2013). Different studies have adopted a qualitative approach to investigate women's experiences of birth and the broader implications of psychological birth trauma on women (Affonso & Stichler, 1980; Faremi, Ibitoye, Olatubi, Koledoye, & Ogbeye, 2014; Fenwick et al., 2003; Kealy, Small, & Liamputtong, 2010; McAra-Couper, Jones, & Smythe, 2012; Taylor-Miller & Leanne, 1994; van Reenen & van Rensburg, 2013). Also, the literature on the psychological impacts of CS and observed association of psychological distress with caesarean delivery highlights the importance of a qualitative approach in providing insights into the psychosocial effects of caesarean birth on women (Clement, 2001; Fenwick, Holloway, & Alexander, 2009; Rishworth, Bisung, & Luginaah, 2016; Taghizadeh, Irajpour, & Arbabi, 2013). A common theme highlighted in these studies is the impact of psychological birth trauma on women and the implications of women's responses to the traumatic experience on not only their wellbeing but that of their child and the broader family dynamics (Taghizadeh et al., 2013). A qualitative approach gives women whose life experiences may have been ignored or silenced by other research techniques a voice (Brenner, 2017). It enables in-depth investigation of complex and sensitive issues, thereby generating new knowledge and ideas around the issue investigated (Thorne, 2000; Thorne, Kirkham, & Macdonald-emes, 1996). Importantly, it encourages the production of detailed and rich data while retaining the original perspectives of the participants in a study and is ideal for addressing questions of 'how', 'what' and 'why' in research (Becker, Bryman, & Ferguson, 2012; Ritchie, Lewis, Mcnaughton Nicholls, & Ormston, 2013; Hazzan & Nutov, 2014; Ritchie, Lewis, Nicholls, & Ormston, 2014).

The research questions (Chapter 1.2) guide the research as it seeks to uncover women's views of their unplanned caesarean birth. Through a feminist lens, the research gain valuable insight on women's lived experiences around birth, and their perspectives, alongside health providers', on the nature of maternity care provision as a catalyst for improving women's birth experiences of operative deliveries.

4.4. Research methods

4.4.1. Ethical considerations

Though it is uncommon for participants in qualitative research to experience physical harm during the interviews, due to the intrusive nature of in-depth interviews, the interview experience may be distressing to some participants (Gibson, Benson, & Brand, 2013; Surmiak, 2019). Therefore, researchers need to be conscious of the moral value of 'doing no harm' and ensure openness, respect, and accountability (Iphofen & Tolich, 2019). This section, therefore, discusses the ethical issues involved in carrying out the research and the considerations made to ensure that the study meets ethical standards for a study with human participants. Critical ethical issues noted in the literature for participants (both men and women) in qualitative research include the right of participation/non-participation, right to give and withdraw consent, confidentiality and privacy, power imbalance, and preparation for the chances of adverse outcomes (Saeedi, Ghazi Tabatabaie, Moudi, Vedadhir, & Navidian, 2013; Farrimond & Farrimond, 2013; Gibson et al., 2013; Karnieli-Miller, Strier, & Pessach, 2009; Richards & Schwartz, 2002; Saunders, Kitzinger, & Kitzinger, 2015; Slowther, Boynton, & Shaw, 2006). Steps taken to address these expectations are outlined below.

4.4.2. Informed consent

Each potential participant was emailed or given a hard copy of the participant/research information sheet (see appendix I) to allow them to read and ask questions if they had any. It was vital to ensure that participants were adequately informed about the study, the research process, their right to participate or decline. It further explained the nature of the interview and how the data will be used.

Before every interview, I went through the research information sheet again with individual participants to further explain the interview and research process. Participants were informed they could stop the interview at any time without any need to explain why they have chosen to do so. Consent to record the interview was requested from and given by all participants from both groups.

4.4.3. Privacy and confidentiality

Participants were informed that data collected for the study would be held in strict confidence. Participants' personal information would not be made public, and each participant was protected by ensuring they remain anonymous and unidentifiable in any written or other outputs. In reporting the findings, each participant was identified using pseudonyms only known to the researcher.

During some interviews, some (service user) participants were emotional and upset, recounting the memories and experience of the birth. In these instances, participants were asked if they wished to end the interview and needed further support. Contact information of the Health and Disability Consumer Advocacy Service and Lifeline was made available to

the participants where they felt they required additional assistance and information on local counselling services. In this case, none of the participants requested to end the interviews.

4.4.4. Criteria for participation

The selection criteria for participants focused on the identifiable characteristics that reflect the breadth and diversity of the sample population. Group A participants (maternity users) were required to be women 18 years and above, living in New Zealand (permanent residents or citizens), who had an emergency CS of a live baby and were between three months and two years post-birth. Women under 18 years of age, non-permanent residents or citizens, diagnosed with a depressive illness or had an elective CS, and those who have had their CS less than three months or more than two years after their childbirth were ineligible to participate in the study. This was to ensure that women had enough time after their birth to reduce the likelihood that telling their birth story might cause distress and allow them to recall details of their birth experience.

Women report the experience of psychological challenges at different times in the postnatal period. There is limited research on the appropriate time after traumatic childbirth to interview a woman. Saisto et al. (2001), cited in Somera et al. (2010), suggested that the third month after birth is a typical period for women who have emergency CS to report disappointment with their childbirth. However, the postnatal period after a traumatic delivery is characterised by different physiological and psychological presentations such as pain, poor sleep quality, fatigue, and sometimes, especially for new mothers, learning to deal with the demand of breastfeeding and caring for the newborn (Coates, Ayers, & de Visser, 2014). These issues can impact women's willingness and their responses to research inquiries.

Group B in the study were Lead Maternity Carers (LMCs) (midwives and obstetricians), who practice within Canterbury, and who manage, organize and provide maternity care for women through pregnancy and birth. This was to ensure that the participants recruited for the study had the requisite experiences associated with the phenomenon of interest, which will be crucial in producing new knowledge relating to the research question.

4.4.5. Addressing cultural concerns

During the ethics application for this study, I confronted the task of addressing any cultural issues in researching the population of New Zealand. It was essential to show awareness of the broader societal and cultural impact which the research could shape or be shaped by irrespective of the chosen research approach. Though a non-Māori and Pākehā (European), the researcher was not oblivious to the importance of ensuring cultural sensitivity and a safe research environment that eschewed cultural risks and avoided blindness to cultural boundaries that may act as instruments of oppression and exclusion. Therefore, it was crucial to reflect on the impact of the current study on Tangata Whenua and be consistent with cultural safety ethics. Hence, avoiding the conscious and unconscious exclusion of Māori in the study and failing to fulfil or acknowledge the responsibilities of partnership and participation inherent in the Treaty of Waitangi, which requires that Māori also benefits from a fair share of the research (Tolich, 2002). The effect of this research on Māori women's experience of maternity care remains potentially meaningful.

As addressed in Chapter Two of this thesis, colonisation and the ostracisation of traditional Māori birthing culture had a considerable impact on the Māori experience of childbirth (Wepa & Te Huia, 2006). Marginalisation and inequalities in birth outcomes among Māori

women and their families persist within a largely Pākehā community, conceivably deepening unsafe cultural practices and comparative isolation. Though the research did not specifically target Māori women, and the researcher did not engage or consult with any local hapu or iwi regarding the study, I consulted with my research supervisor, a senior lecturer and researcher in Maori Health to ensure sensitivity to potential Māori participants. She agreed to provide advice or guidance on responding appropriately to Maori participants should the need arise.

4.4.6. Ethical approval

I sought ethical approval for the study from the University of Canterbury Human Ethics Committee (HEC) and the Royal Plunket Society New Zealand[21] (for participants' recruitment within Plunket centres) (See appendix II). I applied to HEC on the 17th of August 2017. I received final approval on the 20th of November 2017 after the request for minor changes. Also, I applied to Plunket on the 18th of January 2018 and received approval on 28th February 2018.

4.4.7. Participant recruitment

Purposive sampling was adopted to recruit participants for the study. This approach is ideal for a sampling method that does not aim to infer the representativeness of the sample population. It is commonly used in qualitative research and grounds its selection method on participants' characteristics and the study's objective (Emmel, 2013; Morse, 2004; Suen,

[21] The Royal Plunket Society of New Zealand commonly known as Plunket is the largest provider of free community-based health and well-being support services for under-five children in New Zealand. Its purpose is to ensure that every child in NZ gets the best start in life by providing support to new mothers and their babies (The Royal Plunket Society Trust, 2019)

Huang, & Lee, 2014; Ritchie et al., 2014). Recruitment of participants took place between February and May 2018. Participants for the study were of two categories. Group A were women living in Canterbury who have had an emergency CS and are between three months and two years post-birth. Group B were Lead Maternity Carers (LMCs) (midwives and obstetricians) practising in the Canterbury region of New Zealand. I advertised the invitation to participate in the study across Canterbury through different channels. I distributed flyers across day-care centres, supermarkets, the University of Canterbury notice boards, Christchurch Women's Hospital, and Canterbury Plunket Clinics and family centres. Also, Canterbury Plunket and Birth Trauma Support New Zealand advertised the invitation to participate on their official Facebook pages. As these were channels I had planned to explore, they were added to my ethics application and approved as recruitment channels by the ethics committee. This was significant in the study recruitment exercise as it enabled a broader reach to women across Canterbury.

Most interviews with maternity users took place in their homes. Other locations were at Hagley Park and an interview space at the University of Canterbury's Dovedale and Ilam Campuses. Although participants completed and signed their consent forms, the researcher took on negotiating a partnership with the participants (Flemin, 1994). At each interview, participants were taken through the research process, and the researcher emphasised the participant's position as the experts in the study. For reciprocity, the emphasis was placed on participants' right to 'member-check' the interview transcripts after transcription; to add or remove any information they wish to amend before the beginning of data analysis (Flemin, 1994; Given, 2008; Goldblatt, Karnieli-Miller, & Neumann, 2011; Thomas, 2017). This process of negotiation of consent and partnership was undertaken before the start of every interview to foster informed consent.

Lead maternity carers were contacted directly via telephone and emails. The online listing "Find a Midwife" was used to connect with and invite LMC midwives to participate in the study. Midwives who agreed to participate were then emailed the research information sheet. Most interviews with the midwives took place in their offices and cafés and an interview space at the University of Canterbury. Obstetrician LMCs were emailed directly with the information sheets attached. Obstetricians who showed interest in participating were followed up with a phone call and arrangements were made for interview dates and locations. All obstetricians in the study were interviewed in their respective offices. The use of maternity users' and providers' views ensured multiple perspectives of the Canterbury system were captured through this qualitative study.

4.4.8. Thematic/theoretical saturation

Qualitative interviews are impractical to conduct at the scale of a representative size. Therefore, it is often expected that discussions of the appropriate number of participants for the study will emerge. Regardless, statistical methods are not applicable to calculate generalisability, which is not an expected attribute in qualitative research. Throughout the study recruitment for this research, 86 women expressed interest in participating in the study. Preliminary checks for eligibility via emails, text, and phone calls were conducted, and purposive sampling was carried out primarily based on eligibility discussed in the earlier part of this chapter. In the end, a total of thirty maternity users, seven LMC midwives, and four LMC obstetricians were interviewed. Maternity users were aged 21 – 41, with a mean age of 31 years. Most of the women interviewed identified as New Zealand European except for one participant identifying as a Māori New Zealander, one Fijian, one Asian, and two Europeans.

As the focus of the data analysis in the study was qualitative, the criteria for sample size was moderate enough to avoid repetition but large enough to ensure that all necessary perceptions and views were uncovered and captured. It was important to allow for sufficient description of interesting phenomena discussed by each participant (Acaps, 2012; Al-Busaidi, 2008; Liamputtong & Ezzy, 1999; Pope, Ziebland, & Mays, 2000).

Recruitment of maternity users stopped when it was evident that no new information emerged from new participants (Ando, Cousins, & Young, 2014; Morgan, 1997; Saunders et al., 2018). The concept of thematic or theoretical saturation does not only define the point when no new data emerges from successive participants, but it justifies and implies sample size in qualitative studies (Ando, Cousins, & Young, 2014; Baker et al., 2005; Boyle, Thomas, & Brooks, 2016; Cooper, 2011; Davis & Walker, 2010; Mason, 2010). Ando et al. (2014) highlighted some common challenges qualitative researchers experience in using thematic saturation in justifying participants' numbers. The authors argued that while saturation is always assumed with the non-emergence of new concepts or themes, the process of getting to the saturation point is often not described, thus, remains unclear. Similarly, Saunders et al. (2018) describe how the uncertainty about conceptualising saturation in qualitative analysis results in its disproportionate use. After interviewing 20 women, common themes in their individual birth stories were observed. To clear possible doubt of data saturation, I interviewed an additional ten women. It was evident that no new information was emerging from the women; hence, after discussion with my supervisory team, I opted to discontinue data collection.

4.4.9. Data collection – in-depth interview

In-depth, semi-structured qualitative interviews were conducted with women who had unplanned and emergency CS, as well as with lead maternity care providers (midwives and obstetricians). Semi-structured interviews enable a conversational, focused form of communication that facilitates gathering in-depth information (Ritchie et al., 2013). These features allowed the researcher to guide the interview session by asking specific but open-ended questions and provided the flexibility to discuss issues further by probing. A key strength of this approach is the ability to explore further beneath superficial responses to gain subjective meanings that participants could attach to their behaviours, views, and perceptions.

The interviews addressed the study questions around the nature of care and support services for women who have had CS and the scope of available post-natal support. In broader terms, interviews with women (maternity users) explored their birth experiences within the context of their emergency or unplanned CS. The interviews with lead maternity carers' highlight providers' accounts of the nature of care for women during and after unplanned/emergency CS. These perspectives were explored to understand better whether the maternity system is perceived to meet the needs of these women.

For consistency in structure, a uniform methodology was used for the interviews within the individual groups. However, an exploratory approach was adopted during each interview with individual participants. Iliffe et al. (2015) identify that taking this approach encourages the engagement and participation of interviewees while ensuring methodological consistency in the data collection.

4.4.10. Topic/interview guide

A semi-structured interview guide was developed and used for interviews with maternity users and care providers. Each interview guide (Appendix III) was tailored to explore the research questions and meet the research objectives while also fitting in with the expertise of individual groups, that is, the maternity users, midwives, and obstetricians. The interview guide was pilot tested with an initial participant who had an unplanned CS. However, the data from the pilot study was not included in the analysis. For the pilot study, the period after the CS was not considered a criterion for selecting the interviewee. The pilot interview was used to inform the refinement of the interview guide. Subsequently, my supervisory team reviewed the guide and offered expert advice on language, structure, and relevance. The questions in the guide were then modified accordingly to meet the required standard.

The interview guide directed the interview flow, and the order of the questionnaire was not strictly adhered to but was relatively flexible for each encounter. Singer and Hunter (1999) showed that taking this approach in interviewing participants helps the researcher to ensure that each interview encounter is conversational and geared towards a purpose.

4.5. Interviews with maternity users

In-depth interviews were conducted with all 30 women (maternity users) recruited. The use of in-depth interviews enabled women to tell their stories in their own words and with the space to encourage personal reflection on and of their experiences. This is crucial in qualitative studies intending to understand the health experiences of individuals in greater depth (Liamputtong & Ezzy, 1999). The semi-structured nature of the interview schedule allowed for emphasis on issues that were of importance to the participants and helped address

questions around the memory of birth, sequence of labour, decision making, feelings about providers or hospital staff, post-natal care, and experiences. It aided the production of detailed information of participants' experiences and provided context for exploring similar/diverse views. This approach was helpful in answering the research questions and meeting the research objectives.

Twenty-five out of the thirty participants chose to be interviewed in their homes. Women interviewed reported to be comfortable with me (as a male) interviewing them about the research topic. As male conducting interviews with female participants, I was open to the possibility of my gender influencing the interview process. Thus it was anticipated that some women might prefer to be interviewed by a female. As much as participants were friendly, seemed relaxed, and candid as they shared their stories, an option for a female interviewer was provided. All the participants, however, stated that they were comfortable with being interviewed by a male researcher.

My position was to view the interview as a co-constructed encounter and, from the interview process, co-producing knowledge with the women. This reflexivity and positionality was continually communicated to the participants before and during the interviews. However, while my gender may not have been a barrier to engagement, women might have told their stories differently to a female interviewer. Gender roles and men in feminist studies are further discussed in the latter part of this chapter.

4.6. Interviews with health providers

In-depth semi-structured interviews were conducted with eleven health providers (four obstetricians and seven midwives). The majority of the interviews were undertaken at the

office of participants. The duration of the interviews ranged between 45 and 60 minutes. The interviews have guided the researcher, who asked specific but open-ended questions, providing the flexibility to discuss issues further by probing and allowing space for participants to introduce their thoughts.

The interview experience was markedly different from that with maternity users. For example, the providers' experiences span many cases in contrast to the personal experiences of maternity users. While no apparent power conflicts were observed between myself and the health providers, the power balance was different from the interviews with maternity users. Notably, as experts and leaders of maternity care services, providers had in-depth knowledge of both the research topic and the general operation of the maternity system. Their expertise in the area appeared to have been significant in directing the interview flow towards a system focused discourse. Often, participants were observed to lead the interview in their direction by choosing to explore or linking other issues outside the current topic of discussion. This was useful for the richness of the information gathered from the health providers, as new ideas outside the topic guide were developed and explored with participants.

Notably, information from the health professionals provided me with an understanding of the nature of care and support services for women who have CS and the scope of post-natal support. However, the difficulty in recruiting practising physicians is a growing obstacle to research and time pressure has been cited as a significant factor (Asch, Connor, Hamilton, & Fox, 2000; Johnston et al., 2010a). Amidst growing concerns over the shortage of obstetricians in the NZ health system, the pressure to administer care and complete increasing paperwork often affect physicians’ availability and willingness to participate in research. Consequently, the recruitment of LMC obstetricians was a more difficult task, and only four obstetricians agreed to participate. The research is, therefore, potentially limited in the

number of obstetricians interviewed. The study did not aim to claim sample representativeness nor generalisability of the research findings. Instead, it sought to capture a range of views among LMCs (midwives and obstetricians) who, though are not the subjects of the current study, are experts and key informants with the prerequisite knowledge and understanding of the nature of the issues being researched (Jolly, Aminu, Mgawadere, & Broek, 2019). Notably, adopting in-depth interviews to explore the views of participants compensated for the limited number of participants. In-depth face-to-face interviews with the obstetricians provided a space for the free exchange of views with detailed responses.

By interviewing the lead maternity carers (midwives and obstetricians), the study was afforded insight into the professional outlook of workers in the maternity system. Crucially, it provided a broader view of whether the maternity system in Canterbury is perceived to meet the needs of women who have had an unplanned CS. Community health providers participating in health research is essential to the advancement of health services. Investigating issues concerning best practices, guideline operations, quality of care, and access requires soliciting those involved in the practice (Asch et al., 2000).

4.7. Feminist perspectives on in-depth interviews

Feminists have historically challenged positivists' notion of universal knowledge and how men's experiences have been used to represent both sexes (Sharlene & Lina, 2007). These challenges have led to new epistemologies and forms of knowledge with greater affinity to personal experiences (Alcoff & Potter, 1993).

The historical roots of the oppression of women relied on the structures of knowledge which shaped worldviews (Andrews, 2012; Crowe, 1998). Women's everyday practices were

socially organised to reproduce the patriarchal institutionalised views of the social world, which subjected women to a way of thinking about social realities and a version that excluded their contributions (Miller & Smith, 1989). More recently, feminists theorists have advocated for approaches that focus on developing social research centred on women's lived experiences. In addition, there is the call for sociological inquiries to build new knowledge based on women's subjective experiences and social perspectives (Dixon, Skinner, & Foureur, 2014; Smith, 1987).

Qualitative in-depth interviews are considered an ideal vehicle for capturing women's perspectives. Feminist approaches lean towards qualitative interviews as a tool to empowering women by giving voice to women's accounts of their experiences, understandings, and interests, often using a participatory and collaborative research approach (Taylor, 2002). Interviews entail talking with people, hearing their stories, learning about individual perspectives, and giving voice to participate in all areas of public discourse (Gross, 2015; Hesse-Biber, 2007). Feminist ideologies of qualitative research have are on individual perspectives, most often through in-depth interviews to explore the views of marginalized groups (in particular women), and interrogate language and discourses (Gross, 2015). Building research *for and with* women remains a key goal of many feminist researchers, shifting away from paternalistic and repressive traditions of researching *on* women (Taylor, 2002).

Feminist notions of non-exploitative and non-hierarchical interviewing entail the building of a participatory space where the interviewer and interviewee work together in collaboration, via the development of a high level of trust, encouragement of active participation, reciprocity, equity of control of the research process, self-disclosure and personal involvement (Arksey & Knight, 1999). These underlying principles of feminist philosophy

shaped the research questions and interpretations of the current study's findings. Through a poststructuralist feminist lens, the research explores women's experiences of emergency CS within the New Zealand maternity system. It fills in the knowledge gaps in this area by producing rich stories of women's lived experiences through texts.

Listening to women's birth stories and learning from their experiences build valuable knowledge that catalyses social change and drives meaningful maternity systems' developments (Hill-Karbowski, 2014). I hope that the findings from this research would provide real opportunities for empowering women, improving positive birth experiences and achieving favourable birth outcomes.

4.8. Gender role and men in feminist studies: positionality and reflexivity

I first became interested in this topic during my Master's degree programme at the University of Bedfordshire UK. I attended a conference on the contention and debate in the UK about promoting normal birth amidst the growing rate of caesarean section. In my preliminary research on the topic, I become more interested in New Zealand because of its unique midwifery-oriented maternity system and with normal birth being both a national focus and policy standard of midwives who dominate the system.

As a public health student, my research interest has centred around promoting women's voices and pushing boundaries that could foster positive maternal and child health changes. This research so far has focused on meeting these goals.

The place of men within feminist studies remains a long-standing issue in academic debates. Gender differences and identities in research can shape one's positionality and experiences of the power relations between researchers and their respondents, influencing how knowledge is

represented and interpreted (Mullings, 1999). A researcher being reflexive and identifying their positionality is crucial in undertaking ethically sound research (Holmes, 2014).

The notion of positionality can pose a challenge in qualitative data collection as sometimes it raises ethical questions of who is entitled to research what question or group (Wolf, 1993). To this end, some authors believe that common or shared culture and identity with research participants remains a key factor in minimizing the perceived distance between researchers and their respondents (Khan, 2014), in that it helps to build reciprocity through the "insider" position of the researcher about the researched. For example, some researchers believe that a woman researching women positions herself (the researcher) as an 'insider' because of her gender and shared experiences; thus, creating better connections and accessing richer knowledge from participants than a male researcher. However, this view is criticised for attributing researcher-participants engagement solely based on physical identities (Kobayashi, 1994). By showing awareness of positionality and acknowledging beliefs and by being reflexive, researchers can navigate gender or identity barriers in research (Brooks, 2007; England, 1994; Galam, 2015; Mcgraw, Zvonkovic, & Walker, 2017; Mullings, 1999). According to Fischer (2009), a researcher's ability to identify and set aside their internal assumptions that may potentially hinder engagement with the research participants, the collection of the data, and the interpretation of the research findings, can limit the amount of influence of their knowledge and perspectives on the research process. In addition, Mcgraw, Zvonkovic, and Walker (2017) stated that "researchers place themselves and their practice under scrutiny, acknowledging the ethical dilemmas that permeate the research process and impinge on the creation of knowledge" (pg. 1). In this research, I ensured that I was reflexive about my background, values, beliefs, and inclination (Fischer, 2009; Tufford & Newman, 2012). As a male conducting the current study involving women and reflecting upon gender,

ethnicity (as a Black African), beliefs, values, and background, it was envisioned that my identity as an 'outsider' might be grounds for power imbalances between himself and the women. However, Williams and Heikes (2016) argued that gender is never an impassable fence to building trust, rapport and a sense of shared interest and value in qualitative interviews. Similarly, Mullings (1999, pg. 4) was of the view that researchers need to seek positional spaces that are not informed by gender-based identities, "where the situated knowledge of both parties in the interview encounter, engender a level of trust and co-operation." To this end, I adopted the stance of 'supplication' aligning with the views of England (1994), that a researcher can adopt the role of a supplicant, where they explicitly acknowledges their dependence on their participants, and unequivocally accepts that their knowledge regarding the topic being studied is greater than that of the researcher. In practice, ongoing reflexivity during interviews were critical in communicating to participants their relative authority over their own experiences and knowledge of the study topic and was continually reinforced in the researcher's stance as the naive inquirer and the view of his participants as the 'source of knowledge'.

4.9. Connecting the methodology with ontology and epistemology

Social research has highlighted the relationship between ontology and epistemology in terms of how the ontological position affects the epistemological stance. These philosophical positions have been fundamental in clarifying how a researcher's personal beliefs and orientation shape their theoretical standpoint and, in many ways, the approach and process of their research. It is logically impracticable for researchers to adopt different positions in different research, as these positions are not an item of clothing worn or taken off at will when it suits. Ontology and epistemology reflect fundamental philosophical views in conducting social research, affecting the methodological approach and interpretations of

research findings (Marsh & Furlong, 2002). Thus, in the current study, my understanding that interviews facilitate a process of exchanging views reflects my fundamental principle of reality as a 'cooperative venture' built on individual experiences (Guba & Lincoln, 1994; Kuhn et al., 1970; Metzner-Szigeth, 2009). Qualitative methodology using in-depth interviews as a tool for data collection fits well with a constructivist epistemological premise. It demonstrates the analytical relationship between the research ontology, epistemology, and methodology.

4.10. Data trustworthiness

Researchers have applied different criteria to make sense of the strength and trustworthiness of qualitative research. Lincoln and Guba (1985)'s four criteria of credibility, transferability, dependability, and confirmability are often used to check the robustness and rigour of research. Trustworthiness is "the degree of confidence in data, interpretation, and methods used to ensure the quality of a study" (Connelly, 2016, pg. 1). It addresses the "truth value" and "transparency" of the research process and contributes to the integrity and acceptability of the findings (Lincoln & Guba, 1985; Shenton, 2004).

Credibility

Credibility is often related to internal validity (positivist conception) and refers to the "confidence in the truth of the findings" (Lincoln & Guba, 1985, pg. 218). The researcher strives to meet these criteria by ensuring that the research process follows popular guidelines or standard procedures in conducting qualitative research (Amankwaa, 2016; Connelly, 2016; Harrison, Macgibbon, & Morton, 2001). The credibility of data is strengthened through member-checking, triangulation, reflective journaling, and lengthened engagement of participants (Connelly, 2016; Shenton, 2004). According to Lincoln and Guba (1985),

member-checking is the most important means of assessing the credibility of findings and trustworthiness in qualitative research. As earlier reported in this chapter, to ensure the accuracy and validation of the data, I emailed the transcripts of interviews to each participant to clarify, add, or remove details from the transcript if they find a reason to. The member-checking process facilitated shared discussion of the transcript. It further highlights the research data's co-constructed nature, which fits its theoretical position (Birt, Scott, Cavers, Campbell, & Walter, 2016).

Transferability

Transferability refers to the relevance and applicability of the knowledge from the research within different contexts with similar characteristics (Amankwaa, 2016). Though transferability refers to the relevance of the study findings to a different setting, it is different from the quantitative concept of generalisation. In qualitative studies, only a small number of participants and target environment form the study participants, and individual observations are defined by the unique context in which they are observed. Thus it is difficult to conclude that findings from qualitative studies apply to a broader population (Shenton, 2004). However, though the cases may be unique in context, they also form part of the wider group. Thus the chances of transferability remain potent (Denscombe, 2010).

Lincoln and Guba (1985) suggested that strategies to enhance transferability include a thick or detailed description of every aspect of the research to allow readers to have sufficient information to conclude if the study's findings are applicable or transferable to other situations. As such, transferability is often referred to as a form of external validity, as only the reader or consumer can determine this feature (Shenton, 2004). Leung speaks of ‘analytical transferability’, where the applicability of findings is espoused “under similar

theoretical, and the proximal similarity model" (Leung, 2015, pg. 9). The current research findings represent an analysis of both the lived experiences of maternity users (women) who have had emergency CS and lead maternity carers who provide LMC services to women in the Canterbury region of New Zealand. In this research, the participants' demography and rich accounts of their own recorded views and experiences ensured adequate information to infer the transferability of the research findings.

Dependability

Dependability is concerned with the consistency of research findings. It tests the replicability of the research findings with similar participants within comparable settings (Lincoln & Guba, 1985). It relates to the notion of reliability in quantitative research, hence the split in opinion among researchers on the rationale of using traditional quantitative concepts in qualitative studies (Bryman, 2016). Some researchers question repeatability as a criterion for trustworthiness in qualitative research. The expectations of consistency in the experience of respondents and researchers over time as proof of validity does not assume reality as "multiple and constructed" (as espoused in qualitative paradigms), but as "singular and tangible" (Harding & Whitehead, 2012; Sandelowski, 1993, pg. pg. 3).

Confirmability

Confirmability assesses the degree of neutrality of research findings by establishing the level of influence the researcher's perspectives have on the research process and interpretation of the data (Lincoln & Guba, 1985). Researchers adopt methods such as member-checking, presenting findings to external audiences, audit trail, and reflexivity to declare their positioning within the research, thereby limiting/preventing bias (Lincoln & Guba, 1985).

I presented the findings of this study at an international research conference to an audience of healthcare professionals, researchers, and academics and received critical reviews and appraisals of the research methodology and findings (Egwuba, 2019). Also, the fundamental steps taken in conducting the research and preliminary findings were documented and discussed with the research supervisors in peer-debriefing. In addition, adopting and following the systematic process of framework analysis in analysing the data described how the data were analysed transparently.

4.11. Data analysis

Qualitative studies generally produce large amounts of textual or pictorial data generated from either interviews or observational studies and require summarisation, synthesis, and interpretation to make meaning of the data collected and the issue under investigation (Bourgeault et al., 2010; Thorne, 2000; Thorne, Kirkham, & Macdonald-emes, 1996). Approaches to data analysis vary according to analytical tradition and discipline (Bradley et al., 2007). Generally, a standard process of qualitative data analysis involves recording (or writing) and identifying themes (Becker et al., 2012; Silverman, 1993). However, in specific approaches, such as discourse analysis, identifying dominant discourses that reflect peculiar ideological beliefs can also become the focus of the data analysis (Glynos, Howarth, & Norval, 2009; Hammersley, 2002; Jørgensen & Phillips, 2002). For the current study, the framework method (Ritchie & Spencer, 1994) and thematic and discourse analysis (Paltridge, 2006) were adopted to analyse the data. These methods are further described below.

4.12. Framework method

The defining feature of the framework method lies in its structural approach (Ritchie and Spencer, 1994). The technique promotes systematic organisation of the research data in a matrix output of cases/participants (row) and codes (column). This allows for in-depth analysis of key themes across the entire data set whilst ensuring that the context of individual participant's view is not lost, instead remains connected within the matrix (Cameron, Gale, Heath, Redwood, & Rashid, 2013). The strength of the framework method lies in the ability to maintain transparency in the data analysis and the connections within the various stages of the analysis (Braun & Clarke, 2006; Pope et al., 2000; Ritchie & Lewis, 2003; Ritchie & Spencer, 1994; Smith & Firth, 2011).

The method facilitates the interconnection of the different stages of the data analysis. It describes the processes of "sifting, charting and sorting of materials" from the initial stage of data management through to description and explanation of the findings (Bryman and Burgess, 1994, pg. 177; Ritchie & Spencer, 1994; Smith & Firth, 2011). Some authors have argued that the lack of clarity of procedure and transparency in guidelines for conducting qualitative data analysis can be a methodological weakness (Antaki, 2002; Attride-Stirling, 2001). However, Braun & Clarke (2006), cited in Ward et al. (2013), argued that the lack of flexibility and absolute rigidity in guidelines could constrain the analytical process in qualitative research. Therefore, by showing transparency and clarity in the processes while maintaining flexibility in the guidelines, the framework method attempts to address methodological weakness and show methodological rigour in qualitative data analysis.

Some researchers have adopted the use of framework method in applied policy research (Beake, Acosta, Cooke, & McCourt, 2013; Bee, Brooks, Fraser, & Lovell, 2015; Cameron et

al., 2013; Frost, Shaw, Ontgomery, & Murphy, 2009; Iliffe et al., 2015; Kealy et al., 2010; J Smith & Firth, 2011; Srivastava & Thomson, 2009; Ward et al., 2013). Researchers agree that the framework method allows researchers to analyse data from their studies by drawing from previous research on similar topics while allowing new emerging or dissonant themes to emerge from their current study (Beake et al., 2013). The flexibility to adapt inductive or deductive coding techniques within a framework approach permits the combination of emerging concepts or themes from the study to the findings from previous research. Therefore, the method can facilitate the generation of new theories (which could be further tested) and transparently describe and interpret the phenomenon studied in each specific setting, which adds to its methodological strength in applied policy research.

The framework method also suits the analysis of semi-structured interview data to capture different aspects of issues under investigation (Smith & Firth, 2011). It also identifies both similarities and differences in the descriptive data while focusing on the existing relationships of the different segments of the data. By that, it seeks to draw substantial explanations and descriptive conclusions centred around themes by providing clear guidelines to follow in the production of structured, well-defined charts of summarised data (Cameron et al., 2013). As such, framework analysis is not vastly different from thematic analysis. They both share comparable methodological identities in identifying, analysing, and reporting concepts/themes within a data set (Ward et al., 2013). However, the difference lies in the procedures, as framework analysis has a more structured approach. It brings together the identified themes into a matrix by organising all responses to a particular question by individual participants together. Thus, it helps the researcher better familiarise themself with the data and enable easy comparison of views across the participants.

With the increasing use of framework method to analyse primary qualitative data in policy-related health research, and giving the aim of the current study, the framework method was considered appropriate and therefore was adopted for the present study.

Furber (2010) explains the five different phases typically applied in framework analysis which are described below:

State 1: Transcription

Transcription of an oral interview to written words structures the research data in a form that is responsive to the analysis, and it is described as the start of the data analysis task (Kvale, 2011; Rapley, 2007). It is a minor technical process and an essential and integral aspect of the qualitative analysis (Azevedo et al., 2017). A researcher's transcription style or the ability to transcribe all the recorded interviews is determined by many factors, such as the amount of data to be transcribed, the aim and objective of the research, time and financial factors and the researcher's decisions and practices (Azevedo et al., 2017; Kvale, 2011). Most of the interviews were transcribed by the researcher and few by an experienced independent professional transcription service. I adopted a similar transcription style across the data set. For example, only interruptions, pause, and nonverbal gestures that added meaning to words or phrases were noted in the transcripts. After the initial transcriptions, corrections were made to typographical errors simultaneously as the researcher listened to each audio recordings for the second time. The transcripts were then sent to the research supervisors for comments and feedback. All transcripts were then backed up in the University of Canterbury student's cloud-based hard drive for safe-keeping.

Stage 2: Familiarisation of data transcript

Familiarisation is the process whereby researchers become familiarised with the contents of their data transcripts (Ritchie & Spencer, 1994; Srivastava & Thomson, 2009). Most qualitative researchers consider it as the bedrock for conducting good qualitative data analysis (Willig & Stainton-Rogers, 2008). It provides to the researcher an entry point into the data analysis by providing the link to gain insight into and engage with the vast mass of qualitative data (Currie, McKenzie, & Noone, 2019; Furber & Thomson, 2008; Huberman & Miles, 2002; Priddis, Keedle, & Dahlen, 2018; Reed et al., 2017; Ritchie & Spencer, 1994; Willig & Stainton-Rogers, 2008).

Despite conducting all the interviews myself, I read and re-read each transcript while listening to the audio-recording repeatedly to familiarise myself with the dataset. I went through all the discussions, and changing punctuations was necessary to give meaning to words, phrases, and expressions, making the familiarisation process enriching. It made me think about the data more closely and promoted a better understanding of what was happening in the data. In particular, the meaning that participants attached to their thoughts and views were influential in the analysis plan. This process further made the formation of coherent patterns around the data more accessible. It enabled me to construct a pictorial idea of how the data might be coded and the possible emergent themes.

Where familiarisation is not appropriately done, researchers encounter an unavoidable struggle in conducting a high-quality data analysis, as the opportunity to self-immerse themselves into the data to develop initial analytical ideas might be lost (Ritchie & Spencer, 1994; Willig & Stainton-Rogers, 2008). Midgley et al. (2014) highlighted that ‘getting to know’ the data extensively is essential. Thus, familiarisation remains a standard component of the data analytical process in qualitative studies.

Stage 3: Coding

A qualitative analysis follows certain methodological ground rules, for example, a deductive approach which is based upon predetermined structure (Bradley et al., 2007; Braun & Clarke, 2006; Huberman & Miles, 2002), and an inductive approach which is driven entirely by participants' views and experiences (Thomas, 2006). However, these rules are viewed more as 'guidelines' considering qualitative analysis is not set upon a 'rigid process' but contingent upon the researcher and the research context in driving the process (Braun & Clarke, 2006; Creswell, 2013; Guba & Lincoln, 1994). An inductive approach was adopted in developing the coding framework. This involves observing patterns within the data set and the analytical explanation of the patterns, which can inform the development of a series of theories or hypotheses based on the researcher's understanding and direction of thoughts (Bernard, 2018). Thomas (2006, pg. 238) describes this approach as primarily using "detailed readings of raw data to derive concepts and themes". This was carried out by carefully going through the entire data, line by line, and assigning codes to texts, sentences, passages, or paragraphs as concepts relevant to the research question(s) and objectives (Azungah, 2018). The primary purpose of taking an inductive approach is for the research findings to develop through a systematic data reduction technique that discerns, examines, compares, contrasts, and interprets significant or dominant meaningful themes or patterns within the raw data (Thomas, 2006). The definition of meaning in this regard, to a large extent, is determined by the researcher, guided by the research objectives (Berkowitz, 1997). This indicates that the analysis and interpretation of a single piece of data can take multiple approaches depending on a researcher's philosophical orientation, the research question, the research objectives, and, importantly, participants' input.

I used NVivo-12 computer software for the data coding. It aided the sorting, categorisation, and retrieval of meaningful context while identifying existing patterns (themes) in the data. Coding involves assigning a word, phrase, concepts, ideas, or themes to a particular coding category (Gibbs, 2007; Strauss, 2008). It is the process that facilitates the extensive analysis of the collected data. Strauss (2008, pg. 4) calls this the "transitional process", and it begins with a reflection on the collected data to decipher key meanings from the data (Strauss, 2008). Segments of interesting texts (words, whole sentences, or entire paragraphs) worth noting or coding were highlighted and coded to a relevant label. The labels or 'containers', otherwise called 'nodes' or categories, were created to house groups of relevant/similar ideas or concepts. Each node was then described (in a memo) to note an idea or thought that it represents for future use by the researcher (Table 1). This data management process was the start of in-depth analysis of the data, as it enabled me to think more critically about the associations between the initial categories and emerging themes, at the same time, ensuring that the links to the original data were retained.

Developing codes and creating categories			
Text extracts	Codes	Nodes	Memo
The union is telling us, "you must promote normality, you must support normal birth!"	'Expectations of care'	Promoting normality' 'Gold standard of practice'	Participants describing the dominant philosophy of care within the system
What I'm finding as well, is there's a lot of midwives who are practising	'Perception of risk'	'Pushing boundaries'	Participants expressing concerns of philosophy of

dangerously, and I see that quite frequently, and that really worries me; that really concerns me… What I find in New Zealand is this absolute determination to have normal, but without the common sense of saying, "There are certain women who are high-risk, and they shouldn't be delivered in certain areas, but there's also certain women that are low-risk." I think midwives push the boundaries here, - I do. I think some midwives aren't safe, so they'll push and push and push to get a normal delivery, - whatever the cost. I think we have a maternity system we should be proud of, we provide good outcomes for women and babies, and obviously there are areas for improvement in the system.		'Safe maternity care' 'Normal birth absolutism'	practice and professional tension Participants expressing their views of the quality of

	‘Views on maternity system’	‘women-centred’	care of NZ maternity system

Table 3: Developing codes and creating categories

Each code was used to condense or summarise the relevant data and not necessarily to reduce it. The coding process and the choice of the coding method were grounded within a constructivist epistemological lens (Gordon, 2009; Guba & Lincoln, 1994; Metzner-Szigeth, 2009), which means that the coding and categorisation of data were based upon participants’ expressions and experiences within their sociocultural context (Galbin, 1996). Though participants may share likely stories, views, and perceptions, often the individual experience, the belief system, the attitude, and value orientation differed. Therefore, in categorising the coded data, different observed patterns were grouped not necessarily because they were exactly alike but because of the commonalities that they shared even as separate entities.

An open coding (inductive) method was maintained in coding the entire transcripts. An example is shown below where one of the participants - a midwife - discusses the midwifery philosophy and how this influences the practice of most midwives in New Zealand in their determination to push boundaries and promote ‘normal’ birth at all cost. This view was also noted by another participant who described the determination for ‘normal’ childbirth as a

form of "religious zealotry". These concepts were further analysed within the category of 'philosophy of care' (Table 2).

Sample of a coded text		
Case	Coded Text	Category
Dr Earl	I think that with some of these things, that there is some sort of religious zealotry about birth, there is an element of that, much in the same way that there is, if you've read 'north and south' this month or last month with the breastfeeding debate that if you don't breastfeed you're a failure, and so I think there is this absolute belief that this is the way and there is this inability to embrace other options or other possibilities.	Philosophy of care and risk perception
Midwife Liz	I think some midwives aren't safe, so they'll push and push and push to get a normal delivery, - whatever the cost. I find that really really difficult to see, to witness, to hear. That makes me sound like I'm slagging off all midwives, - I'm not, but it is an issue here. That's what I personally believe, that this is an issue. There's a whole lot of safety and a huge risk issue that I think a lot of midwives aren't discussing with their women here, and that's because of the midwifery philosophy.	

Table 4: Sample of a coded text

Stage 4: Developing and identifying an analytical framework

Continuous coding of texts and tagging of relevant contexts into separate categories were done more intuitively as the analysis progressed. Passages coded were revisited, read and re-read to ensure that every coded phrase, sentence, or paragraph was coded into appropriate nodes. Also, to ensure they were meaningful and fitting within the node and help answer the research questions and meet the research objectives.

If a statement or passage to be coded was observed to fit into multiple nodes, texts were coded into all fitting nodes in the first instance. However, nodes were checked repeatedly and

edited to filter out coded texts that seemed out of place, based on interpretation of what the participant has said, what I thought was important, and how I felt it informed what was happening in other parts of the analytical process. I termed this activity as the 'cleaning process' of coding, which perhaps speaks to the subjective nature of qualitative research and, by extension, qualitative data analysis. For example, the statement by Dr Tim. below, in alluding to a different kind of experience within the public and private practice as to how women are cared for, was initially only coded as *'satisfaction'* under the parent node *'experience vs outcome'*. However, two codes – '*continuity of care' and 'difference in standard'* – were later added (Table 3). The researcher observed that the statement also highlighted the 'difference in standard' care experience for women within the public and private practice while stressing that women who experience continuity of care and carer report greater satisfaction.

Coding text into multiple nodes/categories		
Case	Coded Text	Nodes/Categories
Dr Tim	There are two standards in New Zealand; there is a very small private practice and there is quite a large public practice, and I include in that public practice a lot of the independent midwives who are using the hospital as their backup and their support. So the woman is seeing a number of different people, each constantly changing, it may be shift related or things like that, but the small private practices - high percentage of satisfaction - because it is one to one and they may even be seen by the same person, by and large through antenatal care, same person responsible for their delivery, so if you look at satisfaction from a patient-perspective, those who are working in the private sector have higher degree of satisfaction generally speaking.	Continuity of care Satisfaction Difference in standard

Table 5: Coding text into multiple nodes/categories

Similar or connected nodes were later categorised into a larger ‘parent node’, which captured a more comprehensive representation of participants’ views in these areas. This process was vital in facilitating the iterative process of mapping important themes in the data.

Stage 5: Indexing and charting the data into the framework matrix

The initial set of nodes/categories created formed the analytical framework which guided subsequent coding, though new nodes were added as they emerged from subsequent transcripts. Statements that were meaningful and relevant to each node were coded directly to the nodes, and descriptions were done concurrently. NVivo 12 was used for the coding process (Figure 1). Significantly, using NVivo software facilitated indexing referencing of the coding process.

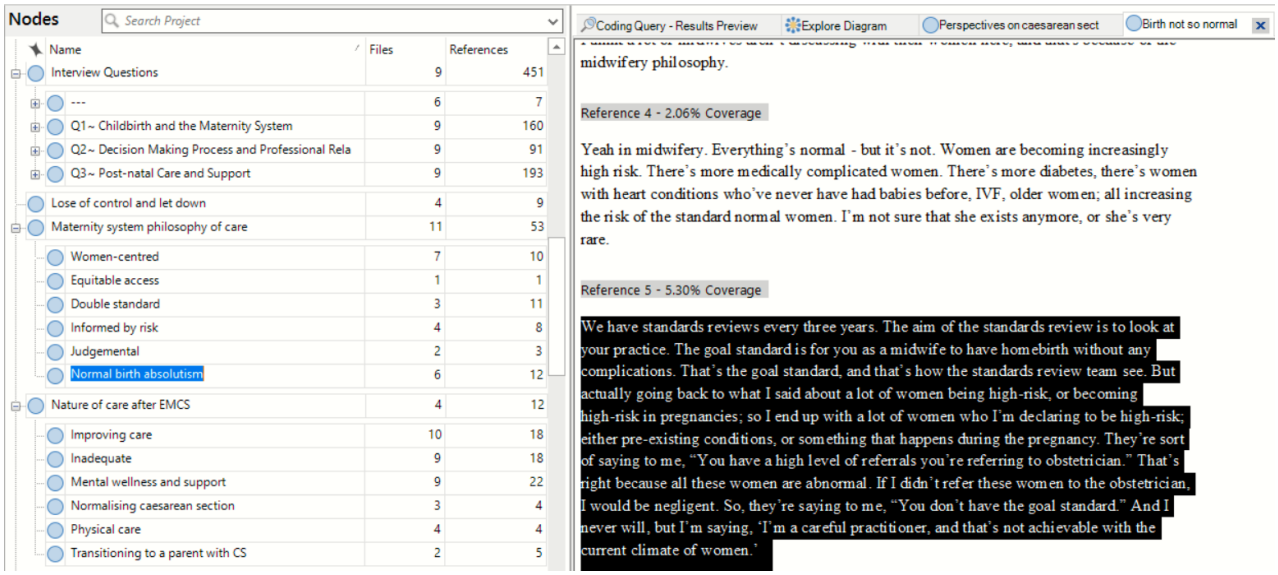

Figure 4.1: Coding using NVivo

Having identified and indexing the analytical framework used in coding all transcripts, the researcher created a framework matrix of the coded data in NVivo. The importance of this was to compress and present the extensive data in a case (row) and theme/node (column)

based format. NVivo was very useful as the researcher did not have to do this manually. This process enabled the researcher to build a picture of the coded data. The charting of the coded data into the framework matrix presented the researcher with the choice of either taking a thematic outlook of the data, analysing the themes across the cases (participants) or the cases across the themes (Ritchie & Spencer, 1994). The latter was adopted for this study (Figure 2). Initially, the framework was charted as a single matrix for all coded nodes. However, matrices were created for individual categories/themes of interest for further analysis and interpretation. Notably, the cases were organised in the same order for individual subject charts. This was crucial to ensure a detailed review of the entire data set for individual cases (Ritchie & Spencer, 1994). Regular meetings with my supervisors on the analysis allowed for further discussions of participants' responses, the nodes, agreement on re-emerging themes, and exploration of deviant cases on the categories and themes.

The chart was then exported to Microsoft Excel. A summary of extracts from the codes and categories was mapped against individual cases (participants) and presented in the matrix (Appendix III: Tables 4, 5, and 6). The indexed data from the previous stage were charted within themes by lifting them from individual case textual context, which was influential in the referencing to identify the particular case each piece of data was lifted from (Srivastava & Thomson, 2009). Where participants' words were found to be concise and clear, thereby not requiring further paraphrasing, verbatim quotes were used and then underlined in the summary to indicate that this was a participant's own words. The pages on individual transcripts were referenced after each summary (see Tables 4, 5, 6). This mapping stage provided a schematic description of the participants' views around different subjects within the issue being studied and provided a guide for the data interpretation. This stage re-emphasises the awareness of the objectives of qualitative data analysis according to Ritchie

and Spencer (1994, pg.186), namely: to define “concepts”, to map “range and nature of phenomena”, to create “typologies”, find “solutions”, provide “explanations” and develop “strategies”. Figure 4.2 shows the analytical framework showing the cases and coded categories with direct quotes. The framework maintains transparency in the data analysis and the connections within the various stages of the analysis (Ritchie & Lewis, 2003; Ritchie & Spencer, 1994).

	A : Philosophy of care	B : Birth not so normal
4 : Dr. R Professional = Doctor	I think that if you look at the age which women are giving birth and if you look at the associated pathology that they are bring with them, we are, that's not just here, we are getting sort of an older, less fit fatter group of women coming through and as a result you kind of work with what you're given. I'm not going to say that there is some sort of religious zealotry about birth but there is an element of that, much in the same way that there is, if you've read 'north and south' this month or last month with the breastfeeding debate that if you don't breastfeed you're a failure, and so I think there is this absolute believe that this is the way and there is this inability to embrace other options or other possibilities. I think people forget that childbirth is dangerous and scary, there are long term issues with it and it doesn't always end up well. There is also that word of mouthing as well, everybody will know someone who had an awful experience	I think people forget that childbirth is dangerous and scary, there are long term issues with it and it doesn't always end up well. There is also that word of mouthing as well, everybody will know someone who had an awful experience I think people forget that childbirth is dangerous and scary, there are long term issues with it and it doesn't always end up well. There is also that word of mouthing as well, everybody will know someone who had an awful experience
5 : midwife - AY Professional = Midwife	in the system I am responsible for that woman's care so I have to ask the doctor, the obstetric team or the Registrars, whoever to come in and give me advice or make a plan. Until I ask them they don't come in. so I spend that time with the woman, and if I'm not 100% sure I either get the charge midwife or the Registrar and they come in and have a chat, we make a plan, usually it ends up with more monitoring of the baby. It's not often that it ends up in a CS. It's usually that something is happening throughout their pregnancy, labour and birth and it gives us heads-up that things aren't going smoothly. I think I had one where I transferred her from Lincoln to Christchurch Women's, she had an EMCS, other than that we are already at Christchurch Women's, and you sort of start going hmmm… we're not overly happy about this	
6 : midwife - A	In terms of looking at emergency caesarean sections, I would hope that my woman are prepared for a caesarean section, - if that happens, I'm not totally focused on normal outcomes. I do talk a lot about risk, and risk about delivering in prime units, delivering at home, but we reiterate that most woman have a normal delivery for sure.	You've got women who have an emergency caesarean section because there's a delay in labour, so they're not dilating as quickly as they should. With that kind of scenario, women are prepared I think, because they know that things aren't happening as it should, or as expected. They can usually see what's going to happen, or you talk to them, you say 'okay, you've been five cm for six hours, we've tried this, we've tried that, you're still stuck at this dilation, and it's looking like the baby isn't going to come out

Figure 4.2: Framework matrix

4.13. Thematic-discourse analysis

Qualitative data analysis seeks to synthesise understanding, explanation and interpretation of the issue under investigation (Bourgeault et al., 2010; Thorne, 2000; Thorne, Kirkham, &

Macdonald-emes, 1996). Generally, the process of qualitative data analysis involves recording (or writing) and identifying themes (Becker et al., 2012; Silverman, 1993). However, in this research, identifying dominant discourses from the data was equally important to make sense of the women's experiences of medicalised birth (Glynos et al., 2009; Hammersley, 2002; Jørgensen & Phillips, 2002). Therefore, I used a 'thematic-discourse' analysis technique for the study. In essence, I conducted a thematic analysis of the data while paying attention to the discourse. This approach was critical in the findings, as I was interested in the text around what normal and medicalised birth means for women and how they talk about it and interpret it?

Thematic analysis was used to pinpoint and emphasise the meaningful patterns across the data set (Becker et al., 2012; Braun & Clarke, 2006; Silverman, 1993). Thematic analysis aids the identification of meaningful patterns within interviews (Becker et al., 2012; Silverman, 1993). Braun and Clarke (2006, pg. 6) describe thematic analysis as "a method for identifying, analysing and reporting patterns (themes) within data". This form of analysis enables a rich description of an event or experience (Neergaard, Olesen, Andersen, & Sondergaard, 2009), which is vital for deciphering meaningful patterns that answer research questions and meet research objectives (Becker et al., 2012; Silverman, 1993). Hayes (2000, p.82) posits that "a theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set". Themes are generated at any point during the research. However, the decision to map an idea or set of patterns into a theme is not a question of the prevalence or quantifiable measures of the concept in the data set. Instead, thorough familiarisation with and knowledge of the data set to conclude whether the idea or ideas capture important views in relation to the research question (Braun & Clarke, 2016; Hayes, 2000). One benefit of using thematic

analysis in qualitative studies lies in its flexibility. Thematic analysis stands out as fitting within different qualitative methods and can be used across different epistemological and theoretical approaches and suited to health systems research (Braun & Clarke, 2006; 2016).

On the other hand, discourse analysis studies how the patterns of language and text establish meanings or ideas on a topic. It is important to understand the socio-cultural context in which the text or language is used (Paltridge, 2006). According to Shaw and Bailey (2009), discourse analysis "offers ways of investigating meaning, whether in conversation or in culture" (pg. 413). It entails analysing language use and other knowledge representations in constructing ideas, negotiation of identities, and accomplishment of actions (Waring, 2017). Gavey (1989) argued that discourse analysis is a consistent way of working with a feminist post-structural perspective. It provides new ways of articulating social discourses and discursive positions between men and women within a given socio-cultural setting. Therefore, it aids the theoretical understanding of these discursive positions, which constitute individual subjectivities, while also questioning the dominant gender relations (Gavey, 1989). Macedo et al. (2008) further stressed that discourse analysis enables the implicit meaning in discourse to be elicited and explained through language and words. The structuring and organisation of words aid the way we define discourses and make sense of reality.

Discourses show how people talk and communicate, do, and believe what they know, which often reflects how they have been shaped by their particular discursive communities[22] (Karlberg, 2005). The language structure often expresses the dominant 'power' within that community (Lakoff & Bucholtz, 2004). As many post-structural feminists believe, language

[22] A discourse community can be described as a group of people who share common set of discourses with broadly set of assumed or agreed public goals, and use communication to achieve these goals (Swales, 1990).

usually serves as a tool to inscribe and frame the potentialities of women, consequently limiting them into a particular way of being (Lakoff & Bucholtz, 2004). There is an element of professional power among healthcare providers, which is often represented in language (Eliassen, 2016). As produced in health communication, power is viewed as an expression of the different forced relations inherent in the space in which they function or operate (Foucault, 1978). Power relations operate through continual struggles and confrontations. It is unstable, produced in sequence and always local in scope (Eliassen, 2013). However, though the balance of power may change, moment by moment, certain fixed characteristics often place the initial advantage on a particular group over the other throughout an encounter. This is often the case in the provider-patient relationship which can impact patients' willingness and in some cases ability to participate in care due to perception of subordination from their caregivers (Nimmon & Stenfors-Hayes, 2016). The interest in discourse in the current study is centred on how it embodies the childbirth lived experiences of women, the impact of their social interactions, and how this helps shape their constructed meaning of social reality (English, 2010). The choice of using a framework method and discourse analysis in the current study was vital to first, explore what ideas are important to women concerning their experiences, and secondly, to unpack the language around support and the ways that midwives and obstetricians talk about their roles, to see if there are differences between the professions and possibly provide an explanation for the existing boundaries.

Summary

In this chapter, the methodology adopted for the research was outlined. The chapter began with a description of the ontological and epistemological positions advocated. I discussed

subjectivism and social constructionism as the epistemological orientation that represents my understanding of the nature of truth and describes reality as subjective. Exploring women's CS experiences from this lens acknowledges that reality or truth can be diverse or multiple. It is a construct of interactions co-constructed between people, society, and culture (Patton, 2015; Walker, 2000). Importantly, its content and structure are dependent upon the individual who upholds them (Lincoln & Guba, 2009). The choice for a feminist poststructuralist perspective in the current study was based on using a research methodology that allows women to share their lived experiences and enable their voices to be heard. The data collection method of in-depth interviews fits with this theoretical orientation as it allowed women to tell their own stories within their social spaces. Feedback and validation of transcripts data sourced from participants were vital to show the integrity and openness of the research process. Peer-debriefing from supervisors also added value to the integrity and robustness of the analytical process. These were vital to demonstrate dependability and trustworthiness. The systemic process followed in the data collection and the framework method of data analysis demonstrate transparency and rigour, which impacted to a large extent the way the interpretation of the research findings was made. These processes were vital as they helped enhance the trustworthiness, reliability, and credibility of this study. In the following two chapters (five and six), the research findings are presented and raw data and synthesised themes were used to articulate the participants' views and discourses.

Chapter Five: Findings from Interviews with Care Providers

5.0. Introduction

In New Zealand (NZ), maternity services operate as an integrated primary, secondary, and tertiary care system. Lead maternity carers are responsible for the continuity of primary care provided to childbearing women from pregnancy, labour, birth, and up to six weeks postpartum (Ministry of Health, 2007b, 2017). Midwives are the lead maternity carer (LMC) in 94.2% of births in NZ, making the country unique among developed nations. Midwifery care represents a conscious departure from medicalised birth as part of a philosophical commitment to primary birth with no medical intervention. As the largest profession, discourses of care have aligned with midwifery philosophies and evident in the use of terminology such as 'abnormality' to connote operative deliveries or the use of high-tech obstetric interventions in childbirth (McAra-Couper & Hunter, 2010). Despite this, hospital births remain high and instrumental deliveries, and caesarean section (which accounts for nearly 30% of all birth) continue to increase nationally (CDHB, 2019a, 2019b; Ministry of Health, 2017).

I examined the perspectives of lead maternity carers to understand their perceptions of intrapartum and postpartum care and support for unplanned and emergency CS within NZ maternity system. In this chapter, a summary of the findings is presented under five main themes (Table 1) that emerged through the data analysis. Collectively, these themes describe the unique features of NZs' maternity system and the implications for the quality of maternity care experienced by women who have unplanned and emergency CS.

Emphasising the importance of health system context were themes (1) "It makes a really big difference": Achieving a woman-centred maternity system through continuity of care, and (2)

The midwifery philosophy of normal birth influences the culture of care. Both themes unpack how NZs unique midwifery-led care system influences health providers' perspectives and highlights the inadequacies in postnatal care after emergency caesarean. Theme (3) "Childbirth is scary and unpredictable" examines how health providers navigate risk amidst perceptions of growing complexity among childbearing women. Theme (4) "End of story! We have a huge amount of power": Influencing women's decision-making describes the power imbalance in the providers-patients relationship, and (5) "They failed at birthing" The emotional and mental dilemma describes health providers' views of the emotional and psychological stress women experience after an unplanned/emergency CS.

Themes	***Sub-themes***
"It makes a really big difference": Achieving a woman-centred maternity system through continuity of care	
Midwifery philosophy of normal birth shaping the culture of care	
"Childbirth is scary and unpredictable"	*Risk and increasing complications with changing demographics*
"End of story! We have a huge amount of power." – Influencing women's decision-making	

"They failed at birthing" The emotional and mental dilemma	*Support with post-traumatic reactions*

Table 6: Themes and sub-themes (care providers' data)

5.1. Theme 1: "It makes a really big difference": Achieving a woman-centred maternity system through continuity of care

Continuity of care promotes a woman-centred care model whereby women may exercise control in different aspects of their care (Soltani & Sandall, 2012). These aspects of LMC care provision were valued by participants who felt it improved perceptions of care among NZ women. For example, some participants stated that: "the fact that we have a continuity of care, and that has been proven in numerous studies, that a continuity of care will give a trust relationship and better birthing outcomes for women" (Midwife Dona), "makes a really big difference in women's experiences" (Midwife Lib). Compared to other countries, most participants rated the NZ system highly and noted that maternity care providers deliver "outstanding" care for most women and babies. Participants attributed the success of the system to the consistent care provided by one or two midwives throughout a woman's pregnancy and six weeks post-partum:

> *I love the care that we provide to women, on that one-on-one basis and getting to know them through the pregnancy allows them to feel more comfortable choosing where to birth and how to birth, to really discover their philosophy around childbirth, and then we can support them to hopefully get the experience that they were after or desire. (Midwife Rose)*

Similarly, Dr Pam noted that:

> *Talking to friends who have babies oversees, one of my friends in Australia had twins and she said 'oh because it was twins a Midwife came to me at home once', and she had a caesarean, and I'm like 'oh that doesn't sound like that much'. (Dr Pam)*

Midwives view the delivery of individualised and women-centred care as prioritising their clients' care choices and supporting them to make informed decisions around their care. Recognising the client's agency is based on mutual respect, trust and shared responsibility which encapsulates the midwifery philosophy that most midwives strive to model their practice by. Midwife Lib shared this view and stated that:

> *Women get to choose somebody who has the same idea with them and who they feel will support them through what they want to do. Obviously, I have my backup and my backup works exactly the same idea as me, so if it is not me, my backup will provide the same care that I do. (Midwife Lib)*

This is important as the client develops a "good trusting relationship" that enables her to be "more at ease and able to talk with and be open" with the midwife (Midwife Rose). Women look to their lead maternity carer for a sense of security (Sjöblom et al., 2014; Werner-Bierwisch, Pinkert, Niessen, Metzing, & Hellmers, 2018). Knowing that the support of their LMC is there gives them confidence and strengthens their relationship.

The universality of midwifery care makes NZs LMC model unique and fundamental in driving high birth satisfaction. One midwife (Midwife Kalie) stated that women's "choice around their carer and place of birth" promotes autonomy and control over the birthing process, which is a critical element of quality maternity care (Grigg & Tracy, 2013). However, some obstetricians felt that while the current system in NZ encourages women to exercise their right of choice in selecting a lead carer, this choice is limited to independent midwives grounded in the presumption of low risk. Obstetricians expressed concern that their knowledge was "marginalised" to providing emergency intervention, Dr Earl explained:

> *There's this sort of feeling that everything will work out and if it doesn't we will be there at the end to salvage things which is not always the way. Certainly a number of the independent midwives have looked after people and we've had it dropped in our laps when there is a problem. I think that there's certainly a feeling that when they did*

> *the [pay schedule], it was not represented or discussed with our professional body which I think tells us where we fit in the scheme of things. (Dr Earl)*

Predominantly, obstetricians claimed that the notion of women's choice of LMC is misleading, as women cannot access publicly-funded obstetric lead carers. Dr Pam explained:

> *One of the principles around it was women having choice. Maybe in the early days they had a lot of choice, I guess one of my concerns now is that women don't have a lot of choice currently, in terms of if you've got the money to pay for an obstetrician then you've got choice, but if you don't have the money to fork out 5000 dollars for an obstetrician, you don't have any choice. (Dr Pam)*

The midwifery-led LMC system in NZ supports continuity of care for women giving birth vaginally. When a woman experiences an obstetric complication, her care is transferred to an obstetrician, often compounding the physical, physiological or emotional difficulties many women encountered after surgery, making recovery more challenging. Participants expressed concern that support was not adequate: "antenatal and birth-related, they get a lot of support but once the baby is born, I think that's where a lot of it gets let down" (Midwife Mei) and "the service is inadequate to support them" (Midwife Liz). According to Dr Tim,

> *In emergency caesarean section, the patient has had a major procedure; there are pain issues, there are functional issues, getting the bladder going again, bowel going again, getting mobile! At the same time, trying to care for a new baby and this could be a first-time mother. This is challenging in a huge number of different fronts. They get 48 hours and they are going to be asked to leave the hospital, and the first 24 hours they have hardly got out of bed. It's a challenge, we don't do it well. (Dr Tim)*

After hospital discharge, most women return to the care of their midwife in the community under the LMC system. Some participants felt that sole reliance on a midwife-LMC to provide postnatal care for women after a surgical delivery might be compromising the care women receive postnatally and, to a large extent, "normalising surgical care" (Dr Tim):

> *I think they are very reliant on the fact that they have their lead maternity carer. That lead maternity carer is a person who will maintain that continuous thread all the way through. Is that person able to then convey to the patient why [they had] the caesarean section? Senior midwives yes, some of the junior ones maybe not as convincingly as a*

> *midwife who has ten or fifteen years' experience. They are learning on the job, even the younger ones are learning that this is an important aspect of care but it takes time to learn that. (Dr Tim)*

In the context of a maternity system committed to providing continuity of care, participants highlighted that the lack of 'continuity in obstetric carer' appears to be overlooked. All participants interviewed believed that caesarean operation could be traumatic for a lot of women. Yet, the post-discharge follow-up by operating surgeons is almost non-existent and poses a continuity of care issue:

> *Quite bluntly really there isn't any opportunity for women to debrief with their surgeon, some of them have quite traumatic caesarean section, and they don't get an opportunity to ever see their surgeon again. (Midwife Mei)*

> *We as midwives, we provide the continuity and then we have to then try and care for her and support her postnatally. Whereas, whoever performed the caesarean, it was kind of just one and ten things that needed to be done, and once that one is dealt with, that's kind of forgotten in a sense. Of course traumatic things will kind of stay with everyone, but it is us that are there sometimes to pick up the pieces. (Midwife Kalie)*

Predominantly, midwives appeared bewildered at the current lack of post-surgical follow-up for their clients with emergency CS. One midwife observed that it is common for patients to have a follow-up visit with their operating surgeon for other major surgeries. She found it difficult to understand why this does not occur following caesarean section. Midwife Kalie described hearing of only a small number of cases in which a woman was seen post-discharge by her operating surgeon, and this occurred when it was "a life or death scenario". Similarly, Midwife Dona observed:

> *Unless there's been a real complication, then the surgeons who did it (CS), and I understand that they're very busy, they don't see the woman again. They just send the ones below them to go and make sure that the wound looks okay, that the bleeding's alright, give them a script and off they go, and that's it. So it is really horrible, sometimes it can be very much like a chop shop. (Midwife Dona)*

Obstetricians shared midwives' frustrations and attributed the lack of follow-up to the working conditions within busy public hospitals:

> *Doctors often feel overwhelmed with the patient load so they don't ever get to see the patients, they just do the basics; temperature, pulse, blood pressure checks, make sure they got pain relief, and they discharge the women before they get to go to a maternity unit, I don't think they debrief at all. (Dr Uri)*

> *It is a fact of life and a busy tertiary referral hospital. You don't have the facilities, or the hours, or the time to be able to do that. (Dr Tim)*

Most doctors said they would like to have post-discharge follow-ups with women; however, this may not be possible for public patients. Obstetricians noted that the funding mechanism for postnatal care, time, working conditions and an overburdened workforce are some of the factors that make this difficult, in contrast with private practice, as one obstetrician explained:

> *Within private practice we always debrief a day after the surgery, then we bring everybody back for a big six week check and then we would talk about the labour and delivery, plan the rest of the postnatal care and then talk to them about what they should do next time. I don't think the public practice offers that service at all. (Dr Uri)*

Having a post-discharge follow-up was seen by participants as an opportunity for the client to have a first-hand debrief with the specialist and to address any unanswered questions that she may have:

> *You get the chance to actually front up and say "well this is what happened, this is why we did it and this is what it means for you in the future. I think for people, it gives them the chance to actually collect their thoughts and discuss it. It actually helps significantly. (Dr Earl)*

Dr Earl's observation that "it actually helps" appears to refer to the importance of understanding why the emergency surgery occurred to mitigate the psychological effects of CS. In sum, participants recognised and were proud of the continuity of care achieved through the NZs LMC system but considered CS to increase the complexity of care required by women. Participants believed that a system of postnatal care involving both midwife LMCs and the operative surgeons would deliver better outcomes for women.

5.2. Theme 2: Midwifery philosophy of normal birth shaping the culture of care

In place for over two decades, New Zealand's midwifery-led maternity system increasingly reflects the dominant profession's views of birth and the culture of maternity care. In the current study, obstetricians and a small number of midwives demonstrated some ambivalence to the goal of achieving 'normal' childbirth, implying that it is an ideological commitment that fails to reflect their professional values. Dr Earl criticised the pervasiveness of the ideology of 'normal birth':

> *I'm not going to say that there is some sort of religious zealotry about birth but there is an element of that. (Dr. Earl)*

> *If you look at the (birthing) classes that are being done, they are pretty much run by midwives or teaching institutions which may have a significant midwifery component…almost to the point where in some classes I have heard that they don't even discuss caesarean section. (Dr Tim)*

Surprisingly, a Midwife similarly felt that the "absolute determination to have normal" birth among midwives fails to reflect the reality of risk in childbirth. She felt the focus on 'normal' compromised midwives' communication of risk in childbirth with their clients, leading to significant delays in identifying women as "high risk" – some not until late in their pregnancy, with potential adverse outcomes. She explained:

> *What I find in New Zealand is this absolute determination to have normal, but without the common sense of saying, "There are certain women who are high-risk, and they shouldn't be delivered in certain ways". I think midwives push the boundaries here, I do. I think some midwives aren't safe, so they'll push and push and push to get a normal delivery, whatever the cost. I find that really difficult to see, to witness, to hear. That makes me sound like I'm slagging off all midwives, I'm not, but it is an issue here…There's a whole lot of safety and a huge risk issue that I think a lot of midwives aren't discussing with their women here, because of the philosophy. (Midwife Liz)*

Midwife Liz here expresses that midwives in the system may be taking the goal of promoting normal birth too far and claimed that this might be due to the confinement of the practice philosophy. Paradoxically, she also advocates for the midwife whom she felt gets caught up

in the conflict of ensuring her practice falls within the philosophical framework of promoting normality. Having the realistic view of the chances of complications in childbirth, while keeping herself safe from possible blame, as often, "if a baby dies, or there's some kind of morbidity, then that is the midwives problem, they always blame the midwife" (Midwife Liz).

Speaking further on the consequence of risk perception, one doctor noted that:

> *Lots of women are identified as being high risk but their risk factors are not really thought about so much in the first trimester so they also miss out on important small interventions like heparin in the first trimester, only because people are not aware of what high risk factors mean for pregnancy later on. (Dr Uri)*

Dr Uri's observations are consistent with the other obstetricians who noted that while many women become high-risk from pre-existing conditions, pregnancy-related complications missed during the early gestational period often contribute to increased use of intervention in childbirth. Available evidence supports this observation (Chadwick & Foster, 2014). The consequence is that many women end up needing one form of intervention or the other to get them through childbirth:

> *A third of women who have never had a baby will need a caesarean section at labour. Of the two-thirds that actually end up not having a caesarean section will need some types of assistants like a forceps delivery. (Dr. Uri)*

While obstetricians framed childbirth as risky, participating midwives noted that vaginal birth results in good outcomes for women and their babies with fewer post-birth complications when compared to caesarean section, observations supported by contemporary evidence (Hung et al., 2016). Midwife Lib was forthcoming in describing how she promoted normal birth by not offering interventions such as epidural, believing that labour pain, for example, is a key component of childbirth and the use of medication to suppress pain during labour can impact both the mother and her foetus. She further stressed:

> *I'm very into the normal birth and I don't provide epidural care. A lot of my women have planned a normal vaginal birth and they get good outcomes. (Midwife Lib)*

Many participants considered the ideological commitment among midwives to normal birth as an essential factor in shaping women's expectations around birth and formulating an 'ideal birth' characterised by minimal intervention.

Public scrutiny of women's birth choices can sometimes cause women to feel judged about their birth decisions. For midwife Mei, this reality is coming for most women irrespective of the birth method:

> *A lot of those women do find that feeling of being judged by the system, by their peers, lots of people. Women feel judged the way that they birth their baby; whether that be that they had an elective caesarean or they had a vaginal birth, either way, there's a lot of judgement. (Midwife Mei)*

While Midwife Mei dismissed any additional stigma accompanying CS, she felt it was a reminder that professional ideologies around childbirth have created a reality in which one ideology is validated as the moral standard against the other.

Similarly, another midwife thought that:

> *We're living in a system for women that is quite judgemental. I feel like there is a lot of pressure around things like breastfeeding, which obviously we know that breastfeeding is best, right? But for some women, when they have a baby and they had a caesarean, there is a huge amount of pressure and guilt that comes with not having a vaginal birth. I think that's probably one of the biggest factors these days. (Midwife Kalie)*

For Midwife Liz, committing to reducing intervention in childbirth results in a professional dilemma in which the quality of her practice lacked in the eyes of her profession, as she explained:

> *The gold standard is for you as a midwife is to have homebirth without any complications. That's the gold standard, and that's how the standards review team see it, but actually going back to what I said about a lot of women being high-risk or becoming high-risk in pregnancy, I end up with a lot of women who I'm declaring to be high-risk, either pre-existing conditions, or something that happens during the*

> *pregnancy… So, they're saying to me, "You don't have the gold standard." And I never will, but I'm saying, 'I'm a careful practitioner, and that's not achievable with the current climate of women. (Midwife Liz)*

The expectation around meeting expectations of norrmal birth is problematised by Midwife Liz due to women's changing demographics and needs, making them more vulnerable to pregnancy and childbirth-related complications. Underpinning this narrative is a critique of the pervasiveness of normal birth as a one-size-fits-all goal for midwifery practice and a sense of frustration that the care Midwife Liz puts into her high-risk patients is not valued in the professional standards of midwifery.

5.3. Theme 3: "Childbirth is scary and unpredictable"

Identifying and managing risks early was considered vital for most obstetricians in determining final birth outcomes. Risk perceptions were highlighted as a critical element in obstetric practice. The need to manage potential risks in pregnancy and childbirth to avoid an adverse outcome informs the recommendation for medical intervention. This theme discusses care providers' views of women's changing demographic conditions and the link with pregnancy and childbirth complications.

5.3.1. Risk and increasing complications with changing demographics

Caesarean section was described as a common experience in childbirth by participants. They noted that while many women go into labour with the expectation of having a normal delivery, a significant proportion have a different outcome. Participants gave various reasons for women experiencing an unplanned CS. Notably, routine interventions such as epidural,

inductions, and failed inductions can increase the risk of complications. In contrast, obstetricians considered that the unpredictable nature of childbirth contributes to emergency CS rates. They stated that things often go wrong in pregnancy and labour and used emotive language to describe childbirth as a risky event that usually does not end well:

> *I guess it is quite a common scenario and I think one of the things with obstetric is that it is so unpredictable and it can change quite quickly. (Dr Pam)*

> *People forget that childbirth is dangerous and scary, there are long term issues with it and it doesn't always end up well. (Dr Earl)*

Obstetricians viewed vaginal delivery as the most 'unpredictable' form of labour and considered caesarean section a 'routine procedure'. Caesarean section was also considered by obstetricians as the safer option with fewer adverse consequences than a vaginal birth, as one participant explained:

> *You have to also think about perineal trauma, vaginal wall trauma, it's really significant for women, and often we would make the decision that a caesarean section would be better than having a vaginal delivery. (Dr Uri)*

Peel, Bhartia, Spicer, & Gautham (2018) suggested that obstetricians' views of vaginal delivery as more risky for women than CS are contributing factors in the increasing rates of unplanned CS. Social researchers have argued that the rising rates of CS have become a threat to the cultural knowledge of a normal physiological process of childbirth and perhaps a push to establish a 'new norm' in childbirth (Hallgrimsdottir, Shumka, Althaus, & Benoit, 2017). This rendering of caesarean section as a safe birth method and vaginal birth as unpredictable was a familiar narrative among obstetricians in the current study. Midwives claimed that such language is capable of influencing women's perception of caesarean sections. Associating risk with vaginal birth is argued to create a culture of fear and uncertainty in the discourses surrounding childbirth (Hallgrimsdottir et al., 2017). Obstetricians appear to ground their practice in reducing 'uncertainty' and appear more

confident when outcomes are predictable and risk minimised. The blurriness of "intrapartum uncertainty" (Page & Mander, 2014, pg. 31), was also expressed by midwives to be a factor in decision making around risk management and client referral:

> *It's not often that everything goes completely normal…You sort of start going hmmm we're not overly happy about this. I have to ask the doctor, the obstetric team or the Registrars, whoever to come in and give me advice or make a plan. (Midwife Lib)*

Midwife Lib's view contrast with Healy et al. (2017, pg. 371), who stated that midwives "sometimes over refer" women to obstetricians for reassurance due to perceptions of risk, thus eschewing responsibility for decision making if something goes wrong. By doing this, Healy argued that midwives might be reneging their professional autonomy to medical professionals. In response, one midwife felt that most midwives are caring for more "medically complicated women" today, with increasing maternal risk complications and lower chances of spontaneous vaginal delivery. In her view, this accounts for the increasing number of referrals by midwives who have a legal, ethical and moral responsibility to their clients. Elaborating on her comments in section 5.2, Midwife Liz explained that if she failed to refer to the increasing number of high-risk clients she was seeing, then she "would be negligent."

One obstetrician further stressed that the "associated pathology" linked with age and other social-demographic conditions set the scene for the increasing likelihood of interventions in childbirth:

> *We are getting sort of an older, less fit fatter group of women coming through and as a result you kind of work with what you're given. (Dr. Earl)*

Socio-demographic conditions as key contributors to rates of CS is reported in the literature (Anderson, Sadler, Stewart, Fyfe, & McCowan, 2013; Manyeh, Amu, Akpakli, Williams, & Gyapong, 2018; O'Dwyer et al., 2013; Rahu, Allvee, Karro, & Rahu, 2019). Maternal

demographics (age, obesity, ethnic differences, and underlining medical conditions) are constantly changing, and these changes are associated with increased pregnancy-related risks, thereby increasing the chances of interventions in childbirth

These findings further highlight the importance of the increasing complexity of the care health professionals needs to provide. The combination of multiple risk factors often results in poorer birth outcomes for women and their babies (Rowland, McLeod, & Froese-Burns, 2012). Providing capacity and care services to mitigate and manage complications in childbirth by monitoring women who may develop risk conditions during pregnancy and childbirth was therefore argued by participants as essential, with implications on rates of caesarean section.

5.4. Theme 4: "End of story! We have a huge amount of power": Influencing women's decision-making

Promoting 'shared power' between providers and patients has been an overarching goal in modern healthcare (Nimmon & Stenfors-Hayes, 2016). Yet, the interaction between maternity care providers and clients is constantly entangled within varying power interplays. In most situations, professionals in their encounter with patients exert or yield power, often in tension with the interest of their clients (Brailey et al., 2017). Across both health professions, participants described the power imbalance in the provider-patient relationship. They recognised themselves as sources of expert advice in the position to influence women:

> *I think women are influenced by professional power. I think ultimately, most people who have come to the hospital have done so for a particular reason; you know they want care, they are going to do what they are told. The reality is as an obstetrician we have a huge amount of power, end of story. I think people argue with me less than when*

> *I was a more junior doctor. Some of that is that I have gotten more confidence, and I guess authority whether I like it or not. (Dr Pam)*

Midwives reported that obstetricians tend to exert the most influence on women. They likened this to women's view of doctors' positions in the organisational hierarchy of the maternity system:

> *Everybody sees doctors and Registrars as, you know, they are on top of the chain. Once they've said "no we are going for a caesarean section", women kind of go 'oh… ok. (Midwife Lib)*

However, some obstetricians disagreed with this view and argued that the rise in interventions in childbirth is a reflection of the increasing risk factors among pregnant women, and their medical knowledge guides doctors:

> *There is an assumption that it's all down to us and that we're driving it but I think that there is a huge groundswell of public opinions saying 'actually this is what I want to do' and that in some ways, the ways that we're practicing is a mirror reflection of what's coming through. It's not just, we are not necessarily leading that. (Dr. Earl)*

Dr Uri supported this view and noted that obstetricians do not recommend caesarean section because "we don't want to be awake all night, or we are bored and we don't want to sit there". Instead, that recommendation is tied to medical indications and managing potential adverse outcomes for the child and the mother. However, the obstetricians did recognise that in most cases, women rarely question their authority and often would go with whatever they recommended. One participant implied that his medical knowledge was always going to influence medical decisions:

> *Do we influence the decision making process? Well, we are there for that reason. (Dr Tim).*

The language and manner of communication between the carer and the woman appeared to play an essential role in communicating 'urgency' and requesting consent. Providers viewed the language as an important aspect of their relationship with women but also suggested that

it is capable of influencing the client's decision to consent to an unplanned caesarean operation or choose to carry on with attempting a vaginal delivery:

> *If we haven't conveyed how important it is, we change our language. So rather than saying to someone this is urgent because the baby is quite distressed, you may have to be quite honest and say "the baby is dying". You may have to change the language because they haven't really appreciated how urgent the situation is or how dire the situation is. (Dr Tim)*

Midwives recognised the importance of this language to persuading women of the urgency of intervention. Midwives identified that the framing of the language used by obstetricians often evoked a sense of fear and imminent danger. Midwife Lib noted that:

> *Because some of them will frame it differently. Some of them will say "you need a caesarean section or your baby is going to die" and in that situation they (women) are not going to say no to a caesarean section, even if I'm going "actually I don't think we do, I think we could leave it for a bit and see what happens. (Midwife Lib)*

The emotive language used to portray birth as "scary and dangerous" can make women lose their confidence to birth naturally. These messages of imminent danger are often to encourage a focus on the 'safety' of a client's and her baby, for example, Dr Tim explained:

> *I think that certainly most mothers at that point in time, in labour, are focused uniquely on the wellbeing of the baby, even at the expense of their own health…if you talk to patients they will say to you "don't worry about me, look after my baby". I usually very quickly correct them saying 'you are both important, I want a healthy mother and a healthy baby'. (Dr Tim)*

As such, a woman is likely to perceive the doctor's narrative as 'the reality' and agree with their expert opinion on the basis that saving her child is all that matters:

> *They think one: the baby's going to die, and two: that they might die too. That's what often woman say to me, 'I thought my baby was going to die'. (Midwife Zillah).*

While her trust is placed on the medical expert as she lies within a medically-controlled space of the hospital arena, her decision choice is not without the fear of uncertainty.

Midwives and obstetricians believe that maternity care emergencies are periods when quick decisions are often made. Irrespective, they all agreed that it is crucial to ensure that clients receive appropriate information about the current situation to make an informed choice and give informed consent, according to the provisions of the 'code of health and disability services consumer's rights regulation 1996' (Health and Disability Commissioner Act, 2012). Though, a lot of the time, due to indications such as a dropping heartrate of the baby, providers reported that "it literally is a black and white and there is no time for discussion" (Dr. Earl) in the decision making as the priority is to ensure the woman and her baby's safety.

A view shared by Midwife Liz, who stated that:

> *If it's an 'emergency - emergency; if it is like, "the heart rate's down, we need to get this baby out", then I'm going to say, 'this is an acute event, we need to get the baby out.' It's not much of a discussion, so it's not much of a choice really for the woman. (Midwife Liz)*

Another doctor explained that emergencies in obstetrics could be chaotic and overwhelming, especially with many health professionals suddenly surrounding the woman and the severity of the situation becoming acutely apparent. Therefore, it is uncommon for any woman to put her unborn child in a precarious position; thus, most women do not object when they are told "you are having a CS":

> *I can't think of a situation in recent years where a patient said to me – "I'd rather not do that, is there another option?" (Dr Tim).*

While the care provider would need to make fast decisions, as the safety of both the mother and her foetus takes priority, midwives predominantly reported that being sensitive to the client's wishes and desires and making sure that she feels heard is crucial. Some midwives described how when a client chooses to object to any form of intervention, even when they are 'high-risk', her choices and decisions may often complicate issues. In such situations, the

midwife tries to be emotionally responsive to her client's wishes and support her with her choices, this may often not result in the best outcome and can be a difficult decision for her as the lead carer:

> *I could think of one that is a stand out for me, where a woman of mine had planned for home birth. She declined interventions like scans and in her third trimester had been seen at Christchurch Women's twice for reduced foetal movement but still declined scan, and that was like wanting to achieve a home birth. She went into early labour and called me but when I was listening with the Doppler, the baby was quite tachycardic, so it took me about 45 minutes of kind of recommending that I thought we should go to Christchurch Women's for a CTG fluids just to sort of source out and if everything was fine. We got in there and within an hour and half of a trace that was average, she was still 1cm, the baby had a massive tachycardia that never recovered and she had an emergency caesarean. (Midwife Kalie)*

Midwife Kalie above reflects on the bounded terrain providers navigate in their quest to co-share power in their relationship with women as they embrace respect for their client's autonomy. While both doctors and midwives maintained that they make efforts to listen to women and make them feel heard, midwives explicitly emphasised the importance of the perceived authority of women's autonomy and birth choices. Midwives identified their role in this regard and noted that it is within their scope of practice to ensure that the nature of the care they provide to women, even under challenging circumstances, respects women's fundamental rights:

> *For all my maternity care, my role is providing women with information to help them make their own decisions. I am very much a midwife who says this is the information and these are the risks and benefits for whatever choice, but at the end of the day it's not my body, it's not my baby, you've got to make that decision for yourself. I'll support you 100% even if that's not the decision I will make. (Midwife Lib)*

Refusing medical intervention or treatment is a right that is unaffected by pregnancy (Code 2, Right 7 (7) of the Health and Disability Commissioner Act, 2019). This right is central to a 'respectful maternity care' that acknowledges that women's choices and experiences of childbirth matter. The care organised and provided to them should preserve their dignity and

respect their informed choice (Boothroyd, 2017; Shakibazadeh et al., 2018; WHO, 2018). However, one midwife stated that the time spent with women during labour, the long hours of work, and the pressure of high client's caseload could contribute to healthcare providers' fatigue and burnout, which may influence how they administer their care. She described that a Midwife in some situations might need to provide lead carer duties for multiple clients in labour consecutively, with some clients possibly in labour for days. In her view, this can contribute to emotional exhaustion and burnout of the midwife, who may then lean towards other alternatives:

> *If I've been with them for more than three or four days before she's in active labour; and then I go to birthing suite with her, I am more likely to want to end this process. Whereas if it was a shift pattern, and I'd only just gone on shift; I'd be saying, "Oh no, it's okay; lets carry on a bit longer. We've got time." Because I think that does affect your decision process as well, because I don't want to be going another 12 hours, even if that might be reasonable. That sounds terrible, but that's how you start to think if you've been awake for 36 hours, you want it to end. (Midwife Liz)*

> *It sounds terrible but we often don't have the time. I've had a whole afternoon of admin, I haven't stopped, and I've just come out of the theatre, the timing and the unpredictable workload. (Dr Pam)*

One obstetrician supported this view and noted the difficulty of managing their unpredictable workload. As such, care providers identified time pressure as an essential factor in the decision-making process around the unplanned caesarean section. Earlier studies by Brown (1996) and Mossialos, Allin, Karras, and Davaki (2005) reported that time-dependent factors and financial incentives are likely predictors of unplanned caesarean section decisions. Similarly, Burns, Geller and Wholey (2012) also identified provider's habits and convenience as a factor in caesarean section decisions. While these findings are comparable to the current study, the individual maternity system settings differ in terms of the funding structure for unplanned or emergency caesarean operations. For example, in New Zealand, emergency and unplanned caesarean sections are publicly funded. Hence, financial incentives from a public

practice perspective may not drive decisions from the perspective of providers. However, time-dependent and leisure-related convenience factors may be factors in professionals' influence on women in making decisions for an unplanned and emergency caesarean section in New Zealand.

Research shows that a high caseload of health providers and the pressure on the maternity workforce can impact the delivery of safe care and the number of times providers spend with their clients, including during labour and childbirth (Smith & Dixon, 2008). The current growth in NZ's maternity labour force is slow at less than 3% in nearly a decade. There are concerns that the net growth rate may fall short of current and future demands (Ministry of Business Innovation and Employment, 2019). Out of the 32 OECD countries, New Zealand has the sixth-lowest number of specialists per head of population, though it ranks 25th of 35 in surgical operations per 100,000 population (Association of Salaried Medical Specialists, 2015; Keegan et al., 2015). The attrition rate for specialist doctors is increasing, and the number of specialists lost to other countries continues to grow (Powell, Stubbs, Hughes, Woods, & Lamb, 2010). Most surgeons in NZ work both in private and public practice, with only about 17.5% working only in private or public practice alone. While this is not peculiar to the NZ workforce, the implication is that there is more inadequate long-term access to public services with increasing wait times and higher workloads (Chambers et al., 2016; Powell, Stubbs, Hughes, Woods, & Lamb, 2010). However, research suggests that 'dual practice' – a system where a health worker works in public and private practice - is beneficial for health worker retention within the public system (Abera, Alemayehu, & Henry, 2017).

5.5. Theme 5: "They failed at birthing" The emotional and mental dilemma

Participants described the emotional and psychological stress many of their clients experienced when their birth failed to go according to plan, especially when they go into labour with the expectation of normal delivery and ended up with an unplanned CS. They expressed that women in such circumstances felt disappointment with their outcome and cited that this feeling resonates from the sense of 'guilt' as women often feel they might have done something wrong during their pregnancy:

> *Most of the women I look after feel very disappointed that that's the way it has gone and often take it on as it was their fault. (Midwife Lib)*

One midwife described her experience of clients who "grieve" (Midwife Dona) over their inability to birth vaginally. According to the participant, "women feel like a failure, like their body, let them down" (Midwife Rose), and this ties to the inability of their labour to progress and them not experiencing a 'real birth'. To one midwife, the 'sense of failure' can lead to emotional and psychological distress, where the woman report feeling she has let her down (the midwife) who spent months preparing her for her birth, and her child who should have been born the natural way:

> *The woman spent hours and hours in labour with an epidural and when it eventually got to 9cms but didn't progress any further, she went with a caesarean section crying her eyes out because she felt like she had failed,, and I think that happens a lot where women feel like they have let the child down and sometimes let you down as a midwife. (Midwife Mei)*

Coming to terms with the outcome of unplanned CS can be difficult, and midwives reported that some of their clients struggle to cope emotionally and even experience difficulty bonding with their newborn:

> *They don't just have the same bonding or connection with their child because of circumstances around the birth. This can affect women severely long term. (Midwife Rose)*

According to midwives' narratives, women having control over their birth, managing the responsibility of getting their body to function well, and meeting the expectation of 'birthing' naturally are essential elements of an ideal birthing experience. For one midwife, a deviation from these goals creates a profound sense of disappointment, and often women feel guilty and incompetent having failed to birth naturally:

> *They get angry as to why their body was not competent enough to do what they need to do. And really, you can tell a woman so many times that actually your body did exactly what it needed to do but your baby was in a funny position, it still doesn't register and they still feel that they had let themselves down. (Midwife Dona)*

Midwives also reported sharing in this feeling of disappointment for not supporting the client to have the birth that she desired and planned for. According to Midwife Zillah, the frustration comes when "the woman hasn't achieved what she wanted for her birth more so than any kind of a disappointment that I no longer have a role. She further stated that:

> *I do have a role but I no longer have a major role in that. So I think I'm more disappointed for the woman that she hasn't achieved what she set out to achieve. So I think my disappointment stems more from that than anything else really. (Midwife Zillah)*

Midwife Zillah appeared to express some mixed reactions to the disruptions caused by the unplanned caesarean section in her professional relationship with her client. The midwife has spent time with her client, and they have both created expectations for the birth. The midwife is optimistic that the time and effort spent would be compensated by the desired and expected labour and delivery. Changes in this dynamics mean that the midwife also shares the feeling of disappointment. Her inability to support her client have the birth she desired and planned for, and the changes in her responsibilities and her role in her client's care contribute to this feeling. Reports from the wider literature suggest that midwives sometimes feel that the

responsibilities (in some cases, blame) fall on them when the birth outcome is unfavourable. In CS, their roles, expertise, and experiences are often not recognised (Litorp et al., 2015). Midwife Dona elaborated on this position, stating that having spent the past nine months with her client to promote a vaginal birth, it was disappointing that the vaginal delivery failed. She went on to state that: "you carry a lot of responsibility and you second-guess yourself", which leaves her with "incredible guilt" (Midwife Dona) that the birth did not come to fruition. This sense of disappointment was also palpable among other midwives.

One participant stated that midwives place on themselves the sole responsibility of promoting and helping their clients to achieve a natural (vaginal) birth because their role is to be "guardians of normal":

> *We are meant to be the 'guardians of normal' and we spent our time trying to promote normal birth with them not in a judgmental way, not in a biased way by any means, but sometimes it actually works out that they feel like they've failed us in some way because you have spent nine months prepping them for something that doesn't eventually happen for whatever reason. (Midwife Mei)*

Interestingly, for the midwives themselves, their shared feeling of 'disappointment' and 'guilt' points to their belief and expectation of a natural (vaginal) birth as the 'standard' and 'ideal'. Thus, the inability to support a client to meet this standard reflect poorly on their practice and their roles as promoters and guardians of normal birth. Therefore, when birth deviates from a natural physiological process to high-tech obstetric delivery, the midwives role and position as the 'ideal carer' becomes threatened:

> *Even if it is not related to anything with my care it still makes me feel most useless almost, because my role is normal so when it becomes abnormal, my role is almost obsolete aside being a support person. (Midwife Zillah)*

Page and Mander (2014) identified that midwives enmesh the concept of normality in their philosophy and expertise. Their expectations are laid within a guarded practice framework,

thereby maintaining a rigid conception of normality. Though, for some other midwives, like for one participant in the current study, the tolerance of uncertainties accentuate a practice philosophy that drifts away from that primary birth to one that is more medical:

> *I'm not totally focused on normal outcomes. I do talk a lot about risk, and risk about delivering in primary units, delivering at home, but we reiterate that most women have a normal delivery for sure… I've been a midwife for 24 years. I trained in the UK, where it's a different system. I guess I'm not a typical LMC from New Zealand. We had a different system whereby you train in a high-risk hospital - a tertiary hospital, and you do some community midwifery. I guess my basis was from a sort of 'an abnormal point of view looking for normal'. The LMC work I do is totally different. Here the focus is on normality – totally! I'm not sure if that's my own personal focus though; mine is about safety and risk. (Midwife Liz)*

In this case, the normality boundary which defines and shapes her clinical decision-making for the woman's care is also a product of her acceptance/tolerance of intrapartum uncertainties, which can either contract or expand her definition of normality (Page & Mander, 2014).

Although most midwives believe that an unplanned caesarean section has negative implications on their clients' birth experiences, the evidence from midwives' narratives also significantly impacts the midwife's role and position and the broader implication for the midwife and the midwifery practice philosophy.

5.5.1. Support with post-traumatic reactions

Providers identified that supporting their clients after a traumatic birth can be a challenging task. One midwife (Midwife Lib) stated that ongoing community support is the "biggest gap" in postnatal care for women who experience trauma in their birth. Another midwife this cited as a systemic failure and a source of dissatisfaction for many of her clients:

> *As far as the mental health side of it, it's much more difficult to access care, it's much more difficult for the woman to understand, where to look for that service. (Midwife Zillah)*

The lack of clinical support can exacerbate the experience of sub-clinical presentations of anxiety and posttraumatic symptoms with an impact on family dynamics (McLeish & Redshaw, 2017). One obstetrician felt that the inadequate mental health support for women with traumatic birth experience might be linked to the high rate of postpartum suicide in NZ:

> *Trauma post-delivery has a significant impact on every single thing to do with parenting afterward. We have such a high rate of suicide. Suicide is the number one leading cause of death postpartum in this country. (Dr. Uri)*

Women can present with the signs of post-traumatic reactions 6-12 months after a traumatic birth (Montmasson, Bertrand, Perrotin, & El-Hage, 2012). With no formal discussions of who is supporting women during this stage, "sometimes, they're fine in those six weeks… But often, it's the 6-12 months afterwards…they start to think, "Oh god, what happened, why did that happen? Often that's the linked with depression" (Midwife Liz). This 'period of silence' becomes significant in their recovery and mental wellness. Some mothers often present with pre-existing mental health issues which they linked to poor follow-up from previous traumatic birth experiences:

> *Potentially, where the system fails for most women is around post-birth, like the support for traumatic birth or even mental illness, because we're only around for six weeks, and we are only funded for a certain number of visits. Therefore, you'll always have the ones who fall in between that, but you will also have the ones who require more care because of the traumatic birth events or mental illness and those sort of things. So potentially, that's where it fails...Mentally there is no support for women. (Midwife Kourtney)*

> *The biggest gap or the hardest thing for us to try and get for a woman is support on-going around mental illness, with post-traumatic birth, stressors, and the support needed in the community. (Midwife Kalie)*

The emotional issues around operative deliveries, especially when unplanned, was therefore argued by participants to increase women's susceptibility to postpartum depressive-type illnesses:

> *There are huge emotional issues, and then of course the whole issue we all understand where you have gone from a very high hormonal level to virtually nothing. I think we are familiar with the terminology like postnatal depression and things like that, certainly that is a huge change in a woman's wellbeing which may ultimately lead to a depression; a depressive-type illness, not just the hormonal changes but the stresses; both physical and emotional, of dealing with this baby and herself as well. Her life has changed, twelve months ago she was free, and she was able to do a lot more, now she is suddenly faced with this whole change of lifestyle. (Dr Pam)*

The currently available services such as the Mothers and Babies Unit and the Emergency Psych Team are "small" and "ill-resourced" due to poor funding and overstretched workforce. These bottlenecks limit the support women receive. According to one participant, "trying to get people into the Mothers and Babies Unit is next to impossible" (Dr Earl). In his view, the poor follow-up and available support for post-partum post-traumatic experiences for women contribute to the "mental health crisis" in the system:

> *I remember one woman who came to me and said, "I'm thinking about harming myself and my children", and you just can't get them seen! What can we do for all of these women? It is certainly under-resourced. How do you deal with that? (Dr. Earl)*

> *I think we need an improvement on what we've got…We need a bigger unit… Emergency Psych Team…is a very small unit and they are not well resourced. (Dr. Tim)*

While GP services remain the first point of call for mental health support, they are often limited in specialist care. Midwives also identified Plunket support as crucial, though most women are challenged by the increasing waiting period for this support:

> *The woman can be extremely traumatised from their experience, we do have a process in place where you send them to the GP, Plunket person or the adjustment programme, but there is a waiting list for 3 months; waiting list for the Plunket programme. The GP is a good place to go but they are quite restrictive on what they offer. I often find the*

> *women are just put on medication to sort of get them the initial postpartum period. (Midwife Zillah)*

There was a consensus between the midwives and obstetricians interviewed of the need for a "mental health service sided with obstetric care" (Dr Uri) that offers specialist counselling support to for women following a traumatic birth experience:

> *I think there needs to be some form of 'birth trauma counselling' available to women that we can assess, and it should be funded, that we can pinpoint to women that we think would benefit from it. (Midwife Kalie)*

> *I think it would be really good, with the counsellor trained in that particular kind of field. I don't even know if there is any but I don't have access to any. I think counselling will enable the woman have a good chat with the counsellor whether they are developing posttraumatic stress syndrome, or whether it is a posttraumatic depression or whether they just need to talk to somebody just to figure those things out. I am not trained in that area so I cannot tell them they've got this you know, I can only refer them to the GP. (Midwife Zillah)*

Summary of findings

This chapter has described how providers conceptualised and discussed their views of New Zealand's maternity system and their perceptions of the continuity of care phenomenon. It also highlighted providers' views of the dominant philosophy of care within the maternity system and how this philosophy informs the perception of risk and the caesarean section rates in Canterbury and New Zealand. From the analysis, care providers' views show how philosophical orientations around childbirth play an essential role in women's conceptualisation of birth ideals, influence professional norms, and inform women's experiences of the maternity system. It also highlights specific inadequacies in postnatal care support for women after unplanned or emergency CS.

In conclusion, from care providers' perspectives, unplanned and emergency caesarean section was described as a major surgery that disrupts women's maternity care journey and the continuity of care experience. Midwives and obstetricians believed that an emergency CS can

have potential short- and long-term implications on women's health and well-being, thus advocating for better support for women, including post-surgical follow-up/debrief.

Chapter Six: Findings from Interviews with Women

6.0. Introduction

This research aimed to explore the experiences, thoughts, and feelings of women who had an unplanned and emergency caesarean section in Canterbury, NZ. When the women in the study shared their birth stories, many of them expressed mixed emotions relating to having had an unplanned caesarean section. Some women described their caesarean birth experience as "sad" (Paige), "traumatic" (Lucy), and "really medical" (Meg). However, some women described their experience as a "walk in the park" (Suz), a "relief", and an assurance of "safety" for their child. The analysis identified that women's experiences of unplanned caesarean birth are affected by factors such as their birth expectations, how abrupt changes were to the nature of care and care provider, and the perception of risk by the LMC, obstetric team and the woman's partner and family. 'The mixed emotions of becoming a mother from an unplanned/emergency caesarean birth' was the overarching theme identified during the data analysis. Competing emotions were evident in participant interviews. For example, though Fiona stated that "I was partly relieved that I didn't have to do the birth, I had such a large baby", she also felt sad and disappointed because "I didn't get to almost have that badge of – I did that myself, I birthed my child myself, and I was capable of doing it". These narratives were pervasive among participants who felt a loss of agency and control over their bodies' ability to birth naturally. The theme, therefore, espouses women's attitudes towards caesarean section and describes the unspoken emotions emerging from their realities of childbirth.

Overarching theme: The Mixed Emotions of Becoming a Mother from an Unplanned/Emergency Caesarean Birth	
Themes	**Subthemes**
1. Motherhood and the conflict of expectation and reality	*"Polar opposites"* *'Ideals and expectations'* *'The bigger picture': When the ideal birth becomes a live and healthy birth'* *'Making decisions: Informed or influenced consent?'*
2. Continuity of care: balancing women's expectations from midwives and doctors	*'Transfer of care experience'*
3. Taking comfort in the everyday during the operative delivery	*Perceptions of hospital staff*
4. The affective responses from separation after birth	*The notion of detachment from infant*
5. Sitting with the sense of responsibility and feeling of failure	
6. "It is a major operation": Resistance to perceptions that caesarean section is an easy way out	
7. "Most other surgeries you do have one": The expectation of post-	

surgical follow-up after a caesarean section	
8. Transitioning to motherhood and changing family dynamics	*Mothering through pain* *The new born mother: Getting caught up with the expectations of motherhood while recovering from a major surgical birth.* *The challenge of breastfeeding and bonding with the newborn*
9. *"I automatically get the option to have a caesarean": The impact of CS on future childbirth choices*	

Table 6: Themes and subthemes

The analysis generated nine major themes, as detailed in Table 6. These themes consisted of 10 subordinate themes. Together, the themes highlight the conflicting feelings participants experienced in their connection to their lead maternity carer (LMC) but disconnection to their experience of emergency caesarean section.

6.1. Theme 1: Motherhood and the conflict of expectation and reality

Researchers have observed that women's birth expectations and experiences are critical factors that impact birth satisfaction, emotional wellbeing, bonding with the newborn, and long-term pregnancy and childbirth decisions (Downe, Finlayson, Oladapo, Bonet, & Gülmezoglu, 2018; Gibbins & Thomson, 2001; Hauck, Fenwick, Downie, & Butt, 2007; Wiklund, Edman, Ryding, & Andolf, 2008). It is common for women to make birth plans during their pregnancy that guide and communicate their wishes and choices about their birth to their carers (Kuo et al., 2010). Alongside participation in postnatal classes, birth plans set women's expectations for their birth and encourage open communication and engagement

between the woman and her care provider. Doing this allows the woman to articulate her thoughts of what she expects her birth to be. Therefore, making a birth plan can help a woman feel a sense of control of her birth as she exercises autonomy and agency over her pregnancy and childbirth (Cook & Loomis, 2012).

This theme is encapsulated below in four subordinate themes that collectively examine the links between birth expectations and experiences and women's perceptions of a systemic focus on 'normal' birth in birthing classes. The section describes how women view their roles in decision making within the context of professionals' mixed practice models and, finally, elaborating on the implications of discourses of risk and safety.

6.1.1. "Polar opposites"

In sharing their birth stories, participants in the study elaborated on the importance of their birth plans in constructing their childbirth expectations. Most women highlighted that a birth plan - which they often make with their partners and, in most cases with their LMC - captures essential details about their birth expectations. For example, their choice of birthplace, the use of epidural or other pain medications, practices such as the rituals of cutting the umbilical cord and having skin to skin contact with their baby immediately after birth and, further key details that correspond to their birth philosophy (Cook & Loomis, 2012). Each woman's experience was unique, though with similar features. Below is a summary of one participant's (Adele) experience concerning her expectations matching up with 'reality':

Adele, a first-time mother, noted that she did not consciously make a specific birth plan during her pregnancy. However, she attended birthing classes and tried to take down

important notes about expectations. Despite her openness, Adele noted that "I didn't for a second ever consider or think that I would need a C-section". She chose to birth at the tertiary hospital (Christchurch Women's Hospital); she had grown up with medical professionals in her family, so choosing a hospital birth was an easy choice. Adele developed gestational diabetes and was induced at 39 weeks. She had two rounds of Sevredol, which in her view, was the start of the 'cascade of intervention'. She stated that "I had like, pretty much every intervention that you can have and ended up with an emergency C-section".

Before her birth, Adele spent four days in the hospital and described her experience as "painful" and "long". Despite going through a lot of pain, she was hopeful she would have a natural (vaginal) birth. Her water was broken at 6:00 pm on Wednesday. She experienced "quite heavy, long, intense contractions" with "very little rest". She felt sick and ended up dehydrated. At 11:00 pm, she had an epidural. At this point, she felt that her birth had become more medical than she had wanted or planned. The following day, Adele felt exhausted from the whole experience. She took a short nap and woke up with her room filled with doctors and medical professionals. For Adele, this was a warning that "things maybe aren't going as they should". In the narrative excerpt below, Adele shares her experience of the times leading to her unplanned caesarean section:

> *I thought I'd been pushing for five minutes, but apparently, it had been two hours, and it was like the magic show again. I'd open my eyes, and there was a room full of doctors, and they were like, "So, you haven't made any progress at all," - like he wasn't anywhere - "So we're probably going to need to give you some assistance, so probably forceps or ventouse, but we're going to take you down to theatre to do it, because if they don't work, then we're going to have to do a C-section." Still, at that point, I was like not even considering that I would need a C-section, I was just like, "Oh, I don't really want forceps, so hopefully they just go with the ventouse option." Because I was fully informed about what they all were so that was a good thing because I feel like if you didn't know about them before you went into it; if they were trying to tell you about it like mid-labour you'd would just, "What the hell is that?" So they did that - I had to sign all the paperwork and stuff - I already had an epidural so that was pretty straight forward. [I] headed down to theatre - it was kind of funny like*

> *being rushed down the hallway with all these doctors and medical staff around you. Then we're in theatre and - I don't know how long it took or anything - but they checked me and they said straight just straight away - like it seemed like it was straight away - they said, "Ah, he's brow presenting." So they didn't even try forceps or ventouse, they were just like, "He's brow presenting, it's a C-section," and I was like, "Oh!" So they did the C-section and he was born.*

Adele's story mirrors the discrepancies in other participants' accounts of their birth expectations and outcomes. Embedded in Adele's narratives is a sense of increasing disconnect from both the passing of time and escalating interventions as her experience of pain, exhaustion, and sleeplessness heightened. Despite her wish for a natural birth, Adele's experience of the 'cascade of intervention' highlights the conflict between expectations of natural delivery and the experience of an unplanned and emergency caesarean section. Despite the 'inevitability' of an operative intervention which Adele alluded to in her account, there is still a disconnect or slight disbelief as she felt surprised when it happened.

The expectations and discourses around birth planning are part of the philosophy of choice and control for women's maternity care. It serves the purpose of positive recollections of birth experience, particularly when the birth plans and expectations are met (Cook & Loomis, 2012). The birth plan often implies that there will be some correspondence, or more, between expectations and reality (Kuo et al., 2010). Therefore, when significant changes occur to women's expectations as a priority in their birth plan, this can cause negative recollections and disappointment over the birth experience with implications for the woman's general wellbeing (Berg, Lundgren, & Lindmark, 2003). The harsh reality of the conflict between Adele's birth plans and her outcome questions the essentiality of her birth plan. Coping with the unfulfilled expectation often demands an adaptation of hope and aspirations to new achievable realities (Hauck et al., 2007).

Most of the women had a similar mindset regarding their expectations around birthing in a midwifery unit and having a natural birth with little or no medical intervention. These thoughts were indicative of women's birth plans, expectations and hopes for how their childbirth would proceed. When asked how their labour and childbirth expectations compared to their experience, most of the participants echoed the incongruence between their birth plans and the experience of an unplanned caesarean section. For example, for Phoebe, "it couldn't have been more different", and Paige spoke of her desire for a planned water birth. Like others, despite her hope for a "natural" delivery, her outcome was far from what she had expected:

> *I had planned to have a natural water birth, and I really wanted it, I wanted to do it with the least amount of drugs involved as possible, but of course, I ended up having to go in for an emergency C-section.*

Paige's account speaks to the chasm between the birth she had imagined and the way her labour progressed. Her use of the phrase "but of course" implies a sense of irony between her expectations and later experience. It indicates a feeling of pessimism in response to her experience and implies that despite her hopes or plans, it was perhaps her bad luck or misfortune that she would end up going the 'worst-case scenario route'. Within this gap between envisioned and actual birth outcomes, a sense of loss emerged in many women's narratives.

The benchmarking of birth experiences to their intended birth plans highlighted the disjuncture between intended and actual outcomes for many participants and feelings of loss of control expressed in the women's accounts. For example, Stella noted that "My birth plan was so far away from what happened - it was crazy! It was completely out of my control". Similarly, Debbie felt like she lost her ability to have control over her birth after she was induced and said that her expectation and her experience was like "day and night":

> *I was expecting to have a normal vaginal birth at Lincoln maternity so that's a primary birthing unit. My pregnancy had been uncomplicated, so nothing suggesting that I was having issues birthing, but then I was overdue, and I had to be induced, and so pretty much as soon as I made the decision to be induced I feel like all of the power, all of the agency was taken away from me.*

Debbie's decision to pursue a primary birth implies a sense of confidence in her body's ability to proceed free from intervention. She describes losing a sense of agency with the decision to be induced. Such a decision necessitates a hospital birth and likely other changes that undermined her birth plan. Talking about the impact of the sudden changes to their birth plans, most women were emotive in describing the difficulty they had in coming to terms with their unfulfilled expectations and unmet needs. Often, women expressed a sense of disappointment at their inability to follow through with natural birth. However, surprisingly, they were forthcoming in justifying this outcome. In Ellen's case, she had planned a VBAC after her previous caesarean section. She was excited about going into labour this time which was not part of her prior caesarean experience. Ellen's narrative excerpt speaks to the importance she placed on finally experiencing a vaginal birth and subsequent disappointment when this was not borne out:

> *I had been hoping for a VBAC. I did go into labour, so that was different from my first child. So I was quite excited to have the opportunity to live a normal birth experience. Didn't quite work out that way…I guess in a way I felt disappointed that I didn't have the experience of like a, I don't know, a normal birth experience. Major surgery is always scary and then you always - with the surgery route - you've always got that six weeks recovery time hanging over your head, which wasn't a massively exciting prospect with a toddler in the house as well. So, I wasn't super keen, but then at the same time, I just wanted to do what was going to be the best outcome for my baby. (Ellen)*

In her statement, Ellen moderated her emotional response of fear at the prospect of surgery and trepidation over recovery while caring for two young children with a pragmatic acknowledgement of her desire to ensure the best outcome. Her lament of the lengthy recovery stemmed from her recollection and possible resilience built from her previous

caesarean section experience. It was a marked difference from most first-time mothers in the study who were more emotional in their descriptions. For example, Fiona stated that:

> *It's difficult to know as a first-time mum, what it is that you need, and how to achieve that. It's easy to look back and go, 'this is what I'd do differently,' but in the moment you're in an extreme situation that you've never come across before. You feel very unprepared and you're very, almost thrown in the deep end, but almost like there's no other way to go about it either. I don't think there's anything that can truly prepare you for having a child until you have it, and then it's just you've got to hope that you cope with it in a way that you'll get through it okay.*

Fiona's statement identifies the difficulty as a first-time mother of a maternal knowledge that is first-hand and of having personal resources that can support the framing of a realistic expectation around childbirth. In this light, she describes a sense of naivety in her experience, though her experience of a caesarean birth transcends this. Therefore, there is an observed conscious shift in her identity. Her narrative suggests that the processing of her adaptive response was influenced by her appraisal of the context of an unplanned CS in which her evaluation of childbirth experience was formed.

The participants' narratives highlight the consequence of the dominant conceptions of natural birth as the ideal against the backdrop of rising caesarean section rates. Karen, whose wish for an "easy birth" was far from what she experienced, noted that everything went wrong for her when she compares her experience with peers who have had a vaginal birth:

> *What I wanted was just a natural, easy vaginal birth and I got the complete opposite… You'd listen to other people's births, and you'd be like, 'oh easy', but then when you hear mine, it's even complicated to explain. Complicated definitely…It was quite horrific.*

In Karen's statement, we see the alternative, in this case, a vaginal birth represented as the "easy" birth and the social norm against which her own experience is contrasted as "horrific." The poststructuralist theory allows the scrutiny of this notion. Some researchers believe that natural birth is embedded within the dominant discourse of the ideal and morally superior. To

understand the ‘reach’ of these discourses, feminists have called for a focus not only on what others say about women in terms of reproductive norms but, importantly, what women themselves say and how they engage with the discourses surrounding childbirth (Miller, 2007). It is evident that Karen benchmarked her expectations against her peers’ birth experiences, and telling her birth story perpetuates a – perhaps false - dichotomy between her complicated birth and what she perceives to be the ‘easy’ birth others experienced. Karen’s perceptions of a natural birth align with the belief that women have the intuitive instinct and innate ability to give birth naturally (Lothian, 2000; Romano & Lothian, 2008). Having one’s labour and birth expectations met is a crucial factor driving positive birth experience and birth satisfaction (Goodman, Mackey, & Tavakoli, 2004; Karlström, Nystedt, & Hildingsson, 2015). Therefore, women’s inability to meet specific labour and birth expectations can lower their birth satisfaction.

Experience of lower mood or emotion and perception of reduced control between a mother and her newborn in the first hours is common among women who undergo an unplanned and emergency caesarean section (Guittier et al., 2014). These unfulfilled aspirations that women constructed as priority expectations resulted in most respondents describing their birth plans and expectations as unrealistic. Their plans did not match the reality of what happened. The attributions and meaning-making resulting from this were women generating new discursive configurations and consciousness around socially-mediated hegemonic childbirth narratives that have smothered their views of reality about childbirth and birthing processes. These are further discussed in the following themes under this section.

6.1.2. Ideals and expectations

Health literacy is a central component of informed decision-making in healthcare delivery, and it is critical in the effective navigation of healthcare systems (Kickbusch, Wait, & Magg, 2005). Improving maternal health literacy has become an essential element of maternity systems to help women and their partners to learn about pregnancy, childbirth, and parenting (McAllister, 2014; Renkert & Nutbeam, 2001). Providing childbirth education improves knowledge and understanding, builds confidence, and helps impending parents learn new coping skills to prepare them physically, emotionally, and psychologically for birth and mothering. (McAllister, 2014; Renkert & Nutbeam, 2001). Most women interviewed felt that the information they received about childbirth from antenatal classes were focused on 'normal' birth and left them feeling unprepared for their eventual caesarean section. Several women felt that the emphasis on normal delivery and narrative of "interventions" in childbirth as the "devil" (Caroline) might have exacerbated their sense of bewilderment that their expectations and experience of birth could differ so significantly:

> *They tell you like medication and pain relief are the devil; obviously, they are not. I think they warp women's expectations because they basically tell you it's going to be fine and it's going to be rosy but it isn't.*

Another participant who shared this view felt that the indoctrination of an 'ideal birth' sets an internalised standard for women. For those who do not meet such expectations, coping with traumatic operative deliveries was more difficult for them.

> *They talk about the ideal and talk about what they want to happen, but it is not happening that way for so many more people. I think they're failing in their care, I really do. I think if they're [antenatal education provider] going to continue with the antenatal classes, they need to talk about the possibility of Caesarean. Just briefly touch on what can happen and what to expect because all they talk about is the 'ideal birth' and ours was not like that at all. (Phoebe)*

Like Phoebe, some of the participants were critical of the information they received in antenatal classes. They thought that the systemic focus on ensuring women achieve a natural (vaginal) birth might be "misleading", mainly as they felt that most birthing classes included only a passing comment about caesarean section. Some participants also believed that the narrative of "hospital births opening up a cascade of interventions" may increase women's anxiety when they are transferred to the hospital due to birth complications. The opportunity to prepare themselves mentally or make informed decisions around their birth choices may also be impacted:

> *The big error the New Zealand maternity system is making is educating us wrongly, because as new parents we went through this parenting course and everyone was warning us, so to speak, that if you go to the hospital your chances of having a caesarean or an assisted birth would increase statistically significantly! It's bullshit! I mean we are scientists, do this test; can you have a caesarean at home? No, you can't! Can you have a caesarean at the primary, I mean the birthing unit? No, you can't! Of course, you know there are more cases of caesarean and elective births at the hospital…I think this is very misleading information…that should be corrected because it's so wrong and it affects a lot of choices. (Eve)*

Like other participants, an emotional sense of betrayal is inferred in Eve's strong language "It's bullshit" as she speaks to the dissonance between her own experience of birth and the content of her antenatal education. Eve's narratives illuminate both the melting pot of information communicated to women about intervention-free labour and childbirth and the reality that one size fits all antenatal education does not meet all women's needs. Though she felt the information she received was a misinterpretation of the statistical data, the literature does identify the elevated risk of interventions with hospital births (Brocklehurst et al., 2016; De Jonge et al., 2017). Findings from most studies do, however, suggest relatively high rates of transfers during labour from primary birthing units and subsequent intervention, mainly among first-time mothers (Brocklehurst et al., 2016; Grigg, Tracy, Tracy, Schmied, & Monk, 2015; Rogers, Pickersgill, Palmer, & Broadbent, 2010a, 2010b; Rowe, Fitzpatrick, Hollowell,

& Kurinczuk, 2012). The findings from these studies show that the rate of transfer of care and the use of interventions in childbirth are more among first-time mothers. Also, they are affected by various factors, including pregnancy-related and other pre-existing health complications, maternal age, the timing of birth, continuity of caregiver, ethnicity, and lack of family support. Thus, highlight the role of socio-demographic characteristics outside of birthplace in increasing interventions in childbirth.

Some women described how they internalised critical information from antenatal classes. One participant spoke of how the information she had received heightened her anxiety on arrival at the hospital, and the environment became a conscious trigger for possible trauma:

> *I was scared and I knew like whether or not it's true but what I learned in the antenatal class was basically "any type of intervention increases your chance of a caesarean" and in my head, I'd made that correlation and I said, "I'm being induced so I'm pretty sure I'm going to end up with a caesarean" and that's what happened. (Jess)*

> *Just being in the hospital environment for a start, I was so anxious! I remember when we were doing our antenatal classes one of the things they said to us is that "if you're anxious if you're stressed you're not going to labour very well, it's not going to happen quickly" and they also said, "if you have an epidural that would slow down your labour"…We had been told about the "cascade of interventions" and they warned us and they said "as soon as you set foot in the hospital, your risk or your chance of having a caesareans goes up" by however many percentages they said it is. (Debbie)*

Debbie's account sets out an internalised checklist of predictors of CS that – rather than increasing her agency – heightened her sense of anxiety over how her birth was progressing. From Debbie's narrative, we see an internalisation that the woman is responsible for how her labour proceeds. Her statement of being warned in antenatal class that the "chance of having a caesareans goes up by however many percentages they said it is" suggests that anxiety rather than other possible biological/physiological causes might pre-empt intervention.

However, few of the participants reported feeling prepared for the possibility of a caesarean section and attributed this to the knowledge gained from attending antenatal classes and

personal research. Some searched for information about CS from the internet and reported that being informed was vital to them and contributed to their ability to manage the emergency better as they were not "in the dark" about it:

> *I did kind of know what to expect because we covered it in antenatal class, I knew roughly that's how long it would take. I knew there would be a ton of people in the room, I couldn't remember what they were all for, and I knew the longest part would be the stitching up at the end, which actually made it faster than I had expected. (Meg)*

> *I had looked up a bit about C-sections just in case because we sort of were advised to just in case things happen. You don't want to be in the dark about everything so I had read up a little bit about it but sort of only just as a 'just in case' scenario. (Carrie)*

These differing accounts from participants highlight the variability in antenatal classes and raise a concern about whether antenatal education content may be based on the professional orientation of the antenatal educators. Reports in the literature on the relationship between antenatal education on a natural delivery and CS rates are contentious (Ferguson, Davis, & Browne, 2013). Though most studies have found no link between antenatal educational content and the use of interventions (Artieta-Pinedo et al., 2010; Bergström, Kieler, & Waldenström, 2009; Fabian, Radestad, & Waldenstrom, 2005; Phipps, Charlton, & Dietz, 2009), few studies suggest otherwise (Cantone et al., 2018; Maimburg, Vaeth, Dürr, Hvidman, & Olsen, 2010). However, evidence shows that women who attend antenatal classes have improved knowledge about labour, childbirth, early parenting, and improved birth satisfaction (Howarth & Swain, 2019; Chikalipo, Chirwa, & Muula, 2018; Gustafsson, Skaghammar, & Adolfsson, 2011; Spinelli, Baglio, Donati, Grandolfo, & Osborn, 2003).

Though a minority, women in the study who reported receiving adequate antenatal information about caesarean section appeared to be more prepared psychologically for the unplanned caesarean birth and described that having the prior knowledge helped them cope better. Previous studies show that women who receive adequate and unbiased information

about other models of care feel better prepared and experience less anxiety from intrapartum complications and unplanned caesarean section (Begum et al., 2018; Phipps et al., 2009). While preventing caesarean section may not be entirely possible, having such information can be an essential addition to birth plans and assist women in developing coping strategies and adjusting their expectations around their birth. From the participants' narratives, we can surmise that an understanding of CS enhances women's preparation. However, a focus on the risk factors for CS can also increase anxiety for many women.

6.1.3. 'The bigger picture': when the ideal birth becomes a live and healthy birth

This sub-theme highlights how birth plans shift and change when the 'ideal' is no longer possible. In evaluating their experiences of surgical birth, participants expressed that concerns for their child's safety became paramount. In Paige's account, for example, her planned water birth reflected her personal and cultural philosophy of childbirth. However, agreeing to an unplanned caesarean section became the "best option" for her as it was a choice made in the interests of her child:

> *I just wanted my son out safe. So I agreed to have the C-section done because it was the best option for him. (Paige)*

Similarly, Lily and Ellen felt that, while it was important for them to achieve the birth they desired, it became more crucial to focus on the 'bigger picture' of preventing harm to themselves and their baby. According to Lily, when the birth became difficult, her expectations were set aside to focus on a healthy baby. Ellen shared this view and stated: "I just wanted to do what was going to be the best outcome for my baby". Similarly, Phoebe

shared her view of her sense of fear, resignation, and relief as she accepted the risk in her situation believing it had led to a good outcome for herself and baby:

> *I remember thinking "if this doesn't happen, it could happen that either I or my baby are not going to make it", and my midwife said it afterward, she said that was the reality; if we hadn't had a caesarean then one or both of you would not be here. Just through all of that, I remember being able to comprehend and then going "okay", and I knew that at that point I'd done everything I could do. So I wasn't happy with the decision but I understood it had to happen and you know what I certainly didn't fight it.*

Phoebe's quote highlights the paradox of women's birth preferences and the reality of risk when labour does not proceed normally. The degree of urgency in her case triggered feelings of 'fear of the unexpected' as Phoebe confronted the possibility of losing her child or her own life. Fear of harm to or death of their child was widespread among most women in the study who felt making a quick decision was "all about getting the baby out safely" and in some cases, "keeping the mom safe" (Jess). Feh also shared this anxiety and fear of risk for her child, which was exacerbated by her previous birth experience:

> *I was quite concerned about my baby's health based on what happened the first time. I was like "Ah, no, really? You had to do this to me?" So, for me, it was just a matter of being able to think as I went through it. (Feh)*

Feh had a preterm birth in her previous pregnancy and noted that she was more concerned about allowing her situation to deteriorate to a "true emergency". Concerned about her history, she had no hesitation accepting the recommendation of her midwife to proceed with the surgery, as she wanted to "sort this out…as quickly as possible" and get things right this time around.

From the participants' accounts, it was evident that the majority viewed the caesarean section as something they would have avoided if possible. However, most participants felt that the uncertainties around their child's safety and their health made them fearful of the 'unexpected', thus accounting for their reactions towards the recommendations for an

unplanned surgical birth. This ‘fear of uncertainty’ was commonly shared and appeared to cause more anxiety than the fear of risk to the child.

The literature identifies that the periods before an unplanned and emergency caesarean section is associated with ‘uncertainties’ (Kealy & Liamputtong, 2011), apprehension, and fear (Herishanu-Gilutz, Shahar, Schattner, Kofman, & Olcberg, 2009). Consistent with international research (Redshaw & Hockley, 2010), participants’ reactions to unexpected surgery were predominantly fear and distress. Women shared their experience of the time leading to their unplanned caesarean section and stated that they were terrified by the thoughts of having a surgical delivery:

> *I was terrified. I certainly didn’t expect to end up having a C-section. Everything in my pregnancy - other than the morning sickness, you know - fine. Everything tracked as normal, the baby was the right way around, so I just thought everything was going to happen as it should. But it didn’t. (Jane)*

> *I was terrified because obviously, it wasn’t what I wanted, it wasn’t the plan, even though I said I’d be flexible but it isn’t the plan and she was in distress and of course everyone comes around this heart monitor and no one will tell me what was going on. (Caroline)*

Having limited knowledge and her lack of control caused Caroline to feel like a passive participant in her birth. Other participants felt that the shock of the moment led to a sense of not being present. Nicole described this as being “out of control”. She succumbed to the understanding that she could do “nothing” but wait as her child is delivered for her by the surgeon. Similarly, for Paige, she stated that “nothing really felt normal” for her. She was engulfed in “shock” and felt “really nervous”. She recalls her experience of feeling faint sensations as the surgeon manipulates through her internal organs to remove her baby from her body:

> *Once I started going numb, the nerves kind of stopped. You stop feeling nervous because you're feeling numb and I was just kind of lying there. It was an odd sensation*

> *because there wasn't much going through my mind. Like I was looking at my partner and I tried to make a bit of small talk because I just kind of felt like I was just kind of lying there and going "what's happening"? You can kind of feel yourself moving, you are wriggling around, you can kind of feel them pulling like there's no pain, but you feel the tugging.*

The changes to women's birth plans were drastic and resulted in them having little or no control over their birth. Most women felt anxious due to the uncertainty that was pervasive in the moments when their labour became complicated. While this was a devastating experience for most women, dealing with the fear of uncertainty meant that having a live and healthy baby by any means outside their preference was their new ideal.

6.1.4. Making decisions: informed or influenced consent?

Women benefit from a self-determined labour and delivery process where they are actively involved in decision-making around their care (Kuo et al., 2010). Even when intervention is needed, women want a sense of control over their birth (Downe et al., 2018; Ngai, 2002). In this theme, I discuss how women frame their experience of decision-making for an unplanned CS. The theme also describes the role and influence of professionals and the anxieties around the urgency of the moment.

The concern for the child's safety influenced the decision of most of the participants. However, healthcare professionals' opinions were equally influential. Obstetric emergencies are often distressing and require quick decisions to be made both by care providers and women. Half of the women interviewed said they had little control in the call to have a caesarean section. They believed that health professionals advise discussions about their child being at risk. For these participants, they spoke of experiencing a sense of loss of control and agency during birth. There were diverse views about shared responsibility between women,

midwives, and obstetric specialists in decision-making. Only a few women described decision-making that reflected an ethos of value for their autonomy and informed consent. They reported that the decision to go ahead with the caesarean section was a choice made from a position of self-evaluation and an assertion of their control and ownership over their birth:

> *It was my decision, yes. It was either giving birth or the caesarean. But once I had made my decision they [obstetric team] were like, that's the best decision, and the midwife was like, I'm pleased you chose that. So really supportive. They didn't put any pressure on me but afterward said that was probably the best outcome. (Suz)*

> *I think that I felt like at that stage it was my decision and that's why I made it then, because...I wanted to be in some sort of control. (Ellen)*

In Olivia's case, when her pain became unbearable, she demanded the caesarean section but was denied for a while which made her unhappy, and she felt her opinion did not matter:

> *I'd been saying for three hours, "I want a C-section, I want her out," because my body was trying to get her out. But they [obstetric team] kept saying no, and my midwife even turned to my husband and said, "You guys need to start really pushing for this situation." Because she'd called distress twice, and they kept saying to her, "No, no, it's fine." When it came to the time and they were - okay the caesarean is happening, we were fine with it, because we already knew that something wasn't right. So in regards to that situation, I don't remember them asking for my consent at that time, but it just happened so quickly. I guess I was like, 'Just get the baby out'. (Olivia)*

The dichotomy of opinions between Olivia and her carers suggests differences in perception of risk. It provides insight into the extent of respect for women's views and autonomy in their care. Discussions over women's involvement in their direct care during labour suggest inconsistencies and controversies in claiming total maternity autonomy for women (Goldberg, 2009; Loke, Davies, & Mak, 2019). Empirical evidence suggests that clinicians' concerns about maternal and foetal safety can impact how they view and incorporate women's perspectives in decision-making during childbirth (Jenkinson, Kruske, & Kildea, 2017). For example, the claim that women's choices can sometimes be in direct conflict with

the safety of the foetus (Brione, 2015), can sometimes cause clinicians to prioritise the goal of holding off harm to the unborn child and the woman through persuasive communication and information management. Though often, within a complex context of mixed practice models, ineffective communication and poor rapport between care providers and women (Jacobson, Zlatnik, Kennedy, & Lyndon, 2013; Vedam, Stoll, Rubashkin, et al., 2017). Most participants spoke of having little time and not being in the proper frame of mind to process the emergency that led to their CS, which impacted how they evaluated the information received from professionals and their active involvement in the birthing decisions.

> *I was quite out of it because I had so many drugs in my system, so it was really you're experiencing those contractions and you've got all these people around and you're sort of thrust this form and, "Read this and sign it"! You're just taken aback with everything that is happening, so you're just like, "They're doctors, they know what they're doing, and I'm just going to sign it". You don't really have the chance to take it all in. (Nicole)*

For many participants, a commonly shared feeling of being overwhelmed and anxious with the fear of losing their child made them less concerned about making an active, informed choice to have the caesarean operation. Karen described having to deal with suppressing her birth preference to ensure her child's safety was uncompromised. Compounded by pain and anxiety, she reported that her consent decision was more to end the long wait than one made from the position of informed choice:

> *I was in so much pain and they were like, "We really need to think about a caesarean section." At that time, I was like, 'absolutely not, I'm not doing this,' and then it started becoming more painful and then I was like, "you know what, let's just face the inevitable, it's happening". So, I was like, "okay, I don't want to do it, but I guess we're going to have to". (Karen).*

Karen's view highlights her stoicism and struggles with increasing pain as her hope for a natural birth was questioned by professionals. Her struggle with the ongoing pain further limits her ability to hold her ground in the face of professional power. Similarly, Feh's

account speaks of anxieties around decisions and the aftermath of a complicated surgical birth. Despite her fears and concerns about consenting to CS, she felt disempowered by medical professionals who were more knowledgeable and experienced. According to Feh, this places her in a "position of power" that is secondary to the medical professionals:

> *I was concerned that it would be more traumatic than necessary because I am aware of the negativity surrounding caesarean birth. I was concerned that I would be pushed into doing something that I'd consider to be unsafe. That was my primary concern; what are they going to make me do now that I'm in this sort of life and death situation, where a decision has to be made. But I'm not really in a position of power here because there are so many people who are so much more experienced than I am.*

The move away from health professionals as experts imbued with high levels of public trust is challenged by calls for health professionals to relate to patients through their worldview (see chapter seven for further discussion). As a result, the patient plays a more active role in the assessment and decision-making process of the care they receive based on personal preference and a shared sense of partnership (Kaba & Sooriakumaran, 2007; Pomey, Ghadiri, Karazivan, Fernandez, & Clavel, 2015). Participants discovered that their planned vaginal birth may not happen as expected. The women's focus shifted from focusing on their personal birth preferences to placing trust in medical professionals. Midwives' professional opinions were trusted in part due to the established relationship with their clients. Eve, for example, described being confident her midwife would make the best recommendations for them:

> *We went in there knowing that because we trusted our midwife 100 percent so we knew that if she will say look, guys – caesarean, we'll say yes caesarean. We were not going to be arguing at all.*

Respect for judgement and opinions of obstetricians, in contrast, was due to a more general trust ascribed to the training and professional competence of physicians. Take, for example, Carrie described the time leading up to her caesarean section. She talked about the conflict of

making decisions around uncertainties and relying on professionals' judgement, mainly when the issues were presented as urgent:

> *I sort of, like, put my trust into the doctors really. There was no "do you mind if we do this?" or "what do you think about doing this?" It was just sort of like "right, we're doing this now." Which to me made me think that they did that because things were dicey and there wasn't really any room for negotiations. (Carrie)*

Similarly, Scarlet and Kate felt that doctors remained the 'experts' in medical emergencies because they have the knowledge and technical expertise to manage risk and avert adverse outcomes. Thus, it was easy to trust them when they make a recommendation:

> *I was asked, I signed consents and everything like that, but I just left it in the hands of those who went to university. I left the call to the doctors. (Scarlet).*

> *Well, the doctor said, "I recommend very strongly that you got for C-section now" and I'm like, "well we don't know, we're not doctors, we don't know what will happen."(Kate)*

This notion of trusting 'the professionals' when it comes to medical decisions was repeated by most participants. Most of the women felt that consenting to an unplanned caesarean section was a 'pseudo choice as, on the one hand, professionals requested their consent but, on the other hand, the decision was effectively already made for them:

> *They basically told me it was happening…It wasn't really a choice, they just sort of said "this is happening, can we do this? We are doing this anyway. So they gave you a choice but there was no choice, they just sort of make you think there was. (Caroline)*

> *I think you have to give your consent but I wouldn't say it's a 100% informed consent because they don't give you options of what if you don't? I didn't ask because I wasn't necessarily against the caesarean section. (Mae)*

> *I wasn't involved, I wasn't involved at all…I remember hearing discussions between one another but never to me about it until the decision was made, and then that was that. (Lucy)*

The narrative excerpts above suggest that some women felt manipulated by requests for their consent in the urgent context of an unplanned CS as alternative options were rarely offered.

Some described that the pressure to accept recommended interventions in an emergency obstetric situation puts their interest between medical dominance and their ability for self-determination and autonomy. They feared that under such circumstances where risk and safety discourses became pervasive, refusing recommended care can potentially foment conflicts between them and the medical professionals, where choices outside medically recommended care may result in them being treated differently or disrespectfully. For other participants, while no conscious thought was given towards refusing the recommended interventions, it was difficult to disregard the influence of medical professionals in their decision to consent to the caesarean section. For example, Meg shares her thoughts on the concept of power and her view of shared knowledge in decision-making:

> *Certainly, there was some influence of power with the caesarean. Obviously, they have power when they suggested that. I didn't question it and I don't think I would question it because when they were recommending it then I just want to do what is medically recommended…There is a fair amount of power that comes with making a recommendation like that. So I think that influenced it (my decision), but in saying that, I don't feel like the caesarean was unnecessary, I feel like it was probably necessary. Although, I don't know because we never had that conversation afterward. (Meg)*

Historically, clinical decision-making on interventions has marginalised women's perspectives (Tully & Ball, 2013). The notion of 'authoritative knowledge' describes how the "authority of knowing" around the process of childbirth switches between different knowledge domains (Davis-Floyd & Sargent, 1997, pg. 477). As the process of childbirth goes on, there is a continuous claim of superior and hierarchical knowledge (who knows best) of the events around the birth among the different assemblages that converge within birthing spaces (Dombroski, Mckinnon, & Healy, 2016). This authoritative knowledge shifts across all actors (the care provider, the woman, and the woman's family) throughout the birth process (Jordan & Davis-Floyd, 1993). The same framework (of authoritative knowledge) is also applied in the transfer from a midwifery model or setting to the Westernise biomedical

obstetric care setting, such as in the case of an emergency caesarean section. Therefore, there is a shift of knowledge about childbirth from the woman to the medical profession. As medical/scientific knowledge remains dominant and the scientific method is viewed as the authoritative knowledge within Westernise cultures, it becomes precedent and socially sanctioned (Jordan & Davis-Floyd, 1993; Tully & Ball, 2013). The dilemma is that other forms of knowledge are devalued.

Summary

In this section, women described making birth plans that articulated certain expectations around their childbirth. The plans made were considered as the 'ideal'. Thus an emergency surgical birth was a deviation from this ideal and, thus, from their expectations. The incongruence and conflict of expectations and experiences were key factors women identified which affected their birth satisfaction and perception of their unplanned caesarean section. The narratives from participants showed that women's expectations and experiences of birth are within certain ideological conformities. Aside from midwives, antenatal educators are influential sources of knowledge that informed many women's views and expectations about childbirth, particularly knowledge specific to natural birth. Predominantly, participants felt compelled to and were concerned about what kind of birth is better or positive, both in terms of safety for their child and perception of the 'norm'. Hence, leaving women competing with conventional expectations of what is 'ideal' in childbirth. Women expressed mixed emotions about their unplanned caesarean section experience in light of their expectations. A pervasive sense of loss characterises their reactions to their unexpected surgical birth and a lack of control over the birth process. Their sense of control was essential and implicit of the

philosophy in which their birth plans sit. Though distrustful of the unexpected surgery, women generally focused on the outcome of the caesarean birth, as the child's safety became paramount. The disadvantages of their experience appeared to have been eclipsed by the evidential avoidance of harm brought about by the caesarean operation. Finally, healthcare professionals play an essential role in how women conceptualise risk in childbirth, thus influencing women's decision-making around the mode of delivery.

6.2. Theme 2: Continuity of care: balancing women's expectations from midwives and the clinical care provider

Continuity of care is an integral part of childbirth experience, and it has been shown to promote women's satisfaction with their pregnancy and childbirth (Perdok et al., 2018). NZ maternity system is unique for its midwifery-dominated care model centred on providing continuity of care for childbearing women during pregnancy, birth and up to six weeks postnatally (Dixon et al., 2017; Grigg & Tracy, 2013). However, women under midwifery care who experience obstetric complications during pregnancy and childbirth experience an abrupt shift of care from their midwife to a hospital-based obstetric specialist (Grigg, Tracy, Schmied, et al., 2015). This can complicate the woman's childbirth expectations with implications for their birth experience. Theme one articulated the incongruence in participants' expectations and experiences of birth. This theme identifies the discrete elements of women's experiences of caesarean birth that collectively depict a discontinuity of care and describes women's lack of control of the dynamics of an emergency caesarean section and the distress and acceptance of the abrupt changes to their lives.

Most participants felt that the transfer of their care from their midwives was a disturbance to their care experience. Predominantly, women were shocked about the care leaving their midwives as they felt they had experienced an uncomplicated pregnancy, “that was obviously something I was not expecting” (Phoebe). Transfer of care occurred at different points for different women when the obstetric-risk situation was identified. For most participants, the transfer occurred during labour and for various reasons, including failed labour progress, foetal distress, tachycardia, and bradycardic foetal heart rate, lower than normal amount of amniotic fluid around the foetus, breech presentation, lazy contractions, posterior presentation, and intrapartum haemorrhage. Paige’s obstetric complication was identified early, and her care transferred to a specialist before labour had commenced:

> *I thought I was going for a midwife appointment on a Wednesday, and he had lost weight, so I ended up going to the doctor's, to radiology to get a scan and they found out that he had pretty much no fluid around him and his umbilical cord had stopped working and he had lost weight. So I was rushed to the hospital that night.*

Paige further narrated that she was offered an option to be induced. The obstetric team also informed her that they could not “guarantee that they'll be able to save him [her child]”, as things could go wrong since the child had no fluid around him. Paige’s experience mirrors that of other participants. For example, Susie described being surprised as she had not thought about the possibility of a transfer or even having her child then. She talked about feeling “gutted” about the sudden change in events as she had only gone for a routine check-up with her midwife. She ended up being referred for an urgent scan and transferred to the tertiary hospital, where she had her caesarean birth.

> *I wasn’t planning to have a baby, so I got my hair cut and then ran in and got the scan. I was getting it dyed, and I thought, ‘I’ll book that, nothing will break your waters and make you go into labour. So I went in, I rang my husband because he likes the scans…Went for the scan, and it was reading that the baby’s growth was quite a lot smaller than it should be. So she [back-up midwife] was a bit concerned. She’d obviously rung the midwife, spoke to the radiographers and everyone there, and they*

> *sent us straight to Christchurch Women's. So what it was is that the baby was in distress, so his heart rate was changing. They induced when we got there.*

Similarly, Kate had booked her birth at a primary unit, preferring a natural birth due to the risk she perceived with epidural use. Kate talked about her mother-in-law going into cardiac arrest after using an epidural anaesthetic when her partner was born. In any case, Kate's waters broke naturally, and she expected that her labour and birth would progress in the same way. However, her contractions were mild and infrequent, and after more than 24 hours, her midwife made the call for a transfer to the tertiary hospital. Though Kates' experience contrast dramatically with her planned natural birth, she felt her experience of being transferred to the hospital and being cared for by hospital staff was far from unpleasant:

> *So my water broke on the Sunday - my baby was due on the Friday and they broke on the Sunday beforehand - at two AM contractions didn't start. So we called the midwife in the morning - because she goes "if contractions don't start straight away, its fine". And so we called her in the morning and she came over and saw us, and she goes "alright, if you haven't had any contractions by seven then we'll go to Christchurch Women's because we're going to have to induce you". So straight away we knew it wasn't going to be what we wanted…It was annoying but it was fine. Like, the midwives were great at Christchurch Women's, so it wasn't an unpleasant experience.*

After transferring care from a midwife to the hospital specialist, the midwife LMC remains the primary carer. However, she does not necessarily see the woman or be present during her delivery (or caesarean section), as she no longer has budgetary responsibility (Grigg & Tracy, 2013; Grigg, Tracy, Schmied, et al., 2015). Describing their experience of these dynamics, some participants felt disappointed when they found out that their midwives would be absent for their delivery. Kate shared this view and stated:

> *I had my midwife but because of the interventions, once I'd been checked into Christchurch Women's I didn't see her until the C-section. That was a little annoying, but I didn't really know what was happening. (Kate).*

Some participants identified the importance of continuity of LMC care to their labour and childbirth experience, "there is a real benefit with getting to see someone so much throughout

the pregnancy and then her being able to be there through it. (Meg). However, when a woman's care is transferred to the hospital obstetric specialist, these dynamics changed as different midwives and clinicians see the woman while in the hospital. Gail explains:

> *In reality, I saw three midwives a day being in maternity wards, on eight-hour shifts, each so every day I would have three more different midwives to see and my life was full of midwives. (Gail).*

Similarly, Mary shared her experience of having little continuity of care before her caesarean section. She started with her first midwife, who transferred her care to a second midwife, who only met weeks before her due date. Mary also consented to a student midwife joining her care. Mary was finally handed over to a third midwife when the second midwife had to attend another birth. Her primary midwife could not attend her birth, and Mary felt she was the one who truly knew her, "I feel like the first one knew me better and like knows better when to like push me? Or like knows me enough to be like yeah you can last, we'll just keep going". Mary felt that her care and experience of continuity of care were negatively impacted when her labour did not progress, and she was transferred to the hospital obstetric care. Describing her experience, Mary felt that:

> *I think they could have cared for me better if they knew me better which is like what I needed from them. I thought I knew the second one (midwife) well as well because I met her a couple of times, I didn't know as well as the first one but the third one I think I'd met possibly once so I feel like I didn't know her very well.*

Mary's account suggests that her continuity of care experience may have been compromised before her transfer and her caesarean section. More changes in her care team during labour further complicated her birth experience. These multiple changes appeared to have impacted the way Mary experienced her transfer/hand-over to the hospital specialist, a phenomenon earlier identified as an obstacle to personal continuity of care and which affects negative

perception of transfer of care and contributes to negative birth experience (De Jonge, Stuijt, Eijke, & Westerman, 2014).

Though some women expressed worry over their midwife LMC's non-attendance at their birth, others felt satisfied over the roles played by midwife LMCs. It was important to the women that their midwives stay with them through their caesarean operation, making them feel safe despite the distressing experience of their complicated medical birth. Women considered the acts of relational care by midwives as comforting and supportive, which had an impact on their CS experience and their perception of midwifery care:

> *I mean she doesn't get paid for C-sections, none of them does because it comes under the hospital, so technically speaking she didn't need to be there, like she didn't have to be there if she didn't want to be but she always tries. So she had a woman going into normal labour that night and she still made the effort to come in there for my son's birth even though she didn't have to. So it was really great. (Paige)*

> *She was great but it was difficult for her because the hospital sort of takes over and it's a little bit awkward for her being an outsider coming into an established system. So I was very satisfied with her (midwife) and with what she did. (Gail)*

Such descriptions of the midwife LMCs support was common among the participants. Women have described midwives' attributes of being sensitive and caring, supportive, listening to them, and having their best interest at heart as reasons they value midwifery care (Homer et al., 2009; Perriman, Davis, & Ferguson, 2018; Walsh, 1999). Most midwives' stay with their in the hospital until after their caesarean section. Women described this as noble, noting that it contributed to their sense of safety during the caesarean section. For most women, this was vital in their decision to retain their midwives as their lead carers for subsequent pregnancy and childbirth:

> *I must say my midwife was exceptional…She'd just come off a shift of delivering a baby, she didn't have to because she wasn't responsible for me. She actually chose to stay with me as a support just because she wanted to support me which was really helpful. Also, because I built that relationship with her, that was fantastic. (Phoebe)*

> *She was really good. We had her because I had her with my first and she'd been really supportive through everything that was going on... She was pretty good at explaining everything that was happening, while it was happening. (Ellen)*

In contrast, Stella experienced some challenges in her relationship with her midwife, which negatively impacted on her experience:

> *I didn't feel as connected to her, because she wasn't there. I didn't see a lot of her. She knew I was going in for the induction. I thought I would have seen her that day, which I didn't. I'm not sure whether she had something on, but I didn't feel, towards the end of it in the hospital that she was there at all. I don't know whether that's because I was such an extreme case. (Stella)*

Kate shared a similar experience and described feeling disconnected with her midwife:

> *I had my midwife but because of the interventions, once I'd been checked into Christchurch Women's I didn't see her until after the C-section. That was a little annoying, but I didn't really know what was happening…In the antenatal care, she was great. For postnatal, she was not as great.*

In Caroline's case, she felt her midwife LMC was more oriented towards a natural birth without medical complications. In her view, while the midwife was supportive during her antenatal period, she felt she was left alone to go through her traumatic experience without LMC support:

> *I will never have that LMC again. I wonder maybe because she is sort of a 'happy day midwife' you know when things all go right, and she doesn't cope so well when things don't go right? She wasn't there, she was there around for the first 24 hours, we were just in a room in [the birthing unit] on our own, and she popped in probably every 3-4 hours and then sent us to Christchurch on our own, so we drove there which apparently we shouldn't have done. She told us to, so we did. And I was still having massive contractions at this point. Then she wasn't there for a while and [she] probably came back to Christchurch Women's around 9-10 pm. We went to Christchurch Women's in the afternoon. They had to call her in early because there wasn't staff to watch me with the oxytocin and they needed someone to sit and watch and everyone was having their babies that night. Then she was there for a little bit and then when they did the epidural or just when they were about to do the epidural she left because she said this is no longer my care, I'm not needed so she left. So she missed all of it really, she missed the birth and stuff which that was sort of hard. (Caroline)*

Caroline's birthing unit to the tertiary hospital where she had her caesarean section is approximately a 32-minute drive. Caroline's comments on having to travel with her partner alone at the instruction of her midwife, as well as her midwife's absences, imply a sense of professional, if not physical, abandonment. According to the Ministry of Health (2007a), the requirement for the midwife LMC when clinical responsibility is transferred to a hospital-based obstetric specialist is for the midwife to continue providing midwifery support to the woman in collaboration with the secondary/tertiary obstetric team. However, the funding mechanism also means that the midwife does not have a legal requirement to continue care at this point.

Besides the transfer method to the tertiary hospital, the LMC midwife is required to assess the woman's condition. Depending on the situation, a private vehicle, an ambulance (road or air) is to be arranged. Notably, the midwife LMC is expected to personally escort the woman or arrange an appropriate escort for the woman during the transfer process (Ministry of Health, 2007a). Clearly, in Caroline's case, she felt that her conditions demanded better care and support from her LMC and felt disappointed because the care she received fell short of her expectations. These experiences highlight the value of the midwife-women relationship and its importance in driving a personalised care model centred on partnership, empowerment, trust, and the promotion of a women-centred continuity of care.

Summary

Most women preferred their LMCs whom they had spent time and developed a close relationship with to care for them during labour. Being transferred and having an unplanned

caesarean section make women feel they lost the continuity of care they hoped for and expected.

6.3. Theme 3: Taking comfort in the everyday during the operative delivery

Theme three describes the participants' perceptions and experiences of CS and narrates the subjective and shared views of the operating room.

As highlighted in the earlier section, most of the women in the study had planned to avoid any form of intervention during their birth, with many planning their births at primary birthing where specialist care is not provided. On arriving at the hospital, some participants were moved into a birthing room, which they described as "really medical" compared to what they had expected" (Meg). These participants felt that the reasons they had initially avoided a hospital birth – the scenery, the rush, the ambience – became their reality. Gail, a first-time mother, spoke of her difficulty transitioning her mind from the "completely different" aura of the "normal birthing ward" at the primary unit where she thought she would deliver her child to a very "medical environment" of the tertiary hospital. She was of the view that the hospital was anxiety-provoking rather than being a place of solace. In the following quote, Gail detailed her perceptions entering the hospital room and seeking out visual reminders of every day to distract her from the stress she was feeling about her impending caesarean delivery:

> *The room was so unfriendly to me; there were three pictures on the wall that were kind of normal pictures. I forget exactly what they were but there was something like a shoe in a handbag and a flower or something and I went in the rest of the room was shiny clean resuscitation equipment here, bed here toilet over there, desk for the nurse there, window there. There were these three places that felt normal and felt like a safe place to be and everything else in the room felt like this is not a good place to be and so I just kept looking at those pictures because I found it really comforting to look at them rather than look at the resuscitation equipment that they might have to use it to try and save my baby's life. I remember thinking I wish someone would provide better pictures*

> *in a more relaxing and comforting environment for people because I think that would have helped my stress levels. (Gail)*

In Gail's narrative excerpt, she described that the items in the room were a conscious reminder of what could go wrong with her birth, which heightened her anxiety. Gail searched for reminders of the familiar and aesthetically engaging as a source of comfort in the room in her visceral response to the environment. Though the hospital environment at this point provided reassurance, she had to seek out safe aesthetic spaces consciously.

The experience of the operating theatre was no different. From the point of arrival at the operating room and during the intraoperative period, environmental factors such as theatre equipment and room settings were reported by participants to affect their level of anxiety. While previous studies have discounted the impact of operative equipment on women's experience of pre-operative anxiety before a caesarean section (Haugen et al., 2009), women's experience in this study suggests otherwise. Some of the participants reported generalised anxiety linked to the sights and sounds of operative equipment. For example, Stella spoke of her memory of entering the theatre. She described it as a scene from the movies and commented on the sense of urgency that engulfed the entire room:

> *I remember the lights, and going down the corridor really fast, thinking to myself, 'It's like watching ER,' because I had all these people, and their heads were saying, "You're going to be okay. We're going to take you in." Then, once I got into the theatre, I remember the lights. It felt like a huge spotlight was on me. And I remember seeing all these faces, again, just like a TV programme. I remember thinking to myself. And when I woke I was like, 'Was that a movie?' It was really - all these lights and all these people, and you could hear everybody shuffling around, and the urgency - you could really hear the urgency in their voice.*

Stella's view of 'urgency' also describes the suddenness of decisions and how promptly different medical professionals responded to her obstetric emergency. The environment of operating rooms are generally far from tranquil and can be anxiety-provoking for many patients from the point of arrival into the room. This is often connected to the physical setting

of the environment, including the presence of surgical instruments that women are confronted with (Jakobsen & Fagermoen, 2005). Illustrating the potential for similar experiences to be perceived differently by women, one participant experienced the operating room positively. She felt that the connection she had with the medical team was friendly and responsive. This made her experience of the room less worrying and reduced her stress and anxiety of the caesarean section:

> *It was quite a good environment, to be honest. My surgeons were singing, so I was like, yeah, sweet. It was good songs, it was good music on. Everyone was really - they'd just done a shift swap, so it was a different team to who I'd been talking to. So they were all in really good moods, and really polite and nice and friendly. It was a pretty good experience. (Anne)*

Anne's experience supports the belief that the behaviour of physicians, nurses, hospital midwives, and other professionals caring for women during CS can reduce women's experience of anxiety. Her use of "team" as the unified approach was important (Beake, Rose, Bick, Weavers, & Wray, 2010). For other women, perceptions of pre-operative anxiety were linked to the experience of induction of anaesthesia. Some women identified experiencing distress which included feeling nauseous, scared, and worried about the administration of the anaesthetic. The absence of partners or support person during this period was a common complaint from participants. Women found not having their partners in the room confusing and emotionally demanding. Like most participants, Ellen's husband was asked to leave before the anaesthetist administered the epidural. She described her disappointment and felt her partner leaving the room only made the distress of the moment worse:

> *It was all very "white" and sterile and scary. Like the spinal thing and anaesthetic they put in, it's a scary thing, and I hated that my husband couldn't be in the room for that part. I was quite sick, I was throwing up and feeling faint. It wasn't an awesome experience. (Ellen)*

Similar experiences of fear and worry in the pre-anaesthetic period are reported in the literature (Haugen et al., 2009; Yilmaz, Toğaç, Çetinkaya, & Toğaç, 2020). Reactions to anaesthesia differ across patients, and a general drop in blood pressure (hypotension) can be a common reaction. Dizziness and feeling nauseous can also be observed among different women (Honarmand, Safavi, Chitsaz, & Jabalameli, 2012; Mavridou et al., 2013; Ryu, Choi, Park, & Kang, 2019). Though medical professionals well manage the process of administering an anaesthetic, the experience can be intense for some women and may cause mild to major preoperative anxiety (Maputle, 2018). Companionship, reassurance by physical touch, emotional support, and ongoing communication between the woman and those closest to her are some factors that can help the woman cope and manage the anxiety (Bohren, Berger, Munthe-Kaas, & Tunçalp, 2019). In Ellen's case above, it was evident that her husband's absence was an important factor in the ways she reacted to the anaesthetic. Kourtney shared this sentiment stressing the importance of having her partner with her throughout her time. In her view, it is not just to ensure that the partner did not miss out on the birth experience, but also because having him around offered her comfort and a sense of security and trust:

> *It would have been a lot more terrifying if I didn't have him there and I often feel for the women who have generals (anaesthesia) because they don't have anyone there for them apart from maybe their midwife. Even if I was asleep, I think I will be a lot happier if my husband was in the room with me. I don't know why because you're trusting all these random people with your body. I think I would have been devastated if I'd had to have a general for whatever reason and he couldn't have been there. (Kourtney)*

Another fear that some participants cited was the possibility of them feeling the pain of the incision. Some women reported feeling apprehensive of the period just after the anaesthetic injection and before the operation. They attributed this apprehension to doubting the potency of the anaesthetic and the chance that they may feel the pain while being operated on:

> *It's, of course, silly to say but one of my biggest fears was that it wasn't going to numb properly and I was going to feel them cutting into me and that it was going to hurt and of cause it doesn't happen like that, they make sure it doesn't happen but all those kind of fears go through your head like you know there's a risk that they could accidentally cut next to your baby you know? They are cutting into you and all this other stuff like you hear stories of bad things and you're like oh god! (Paige)*

> *I think I may have concerned the anaesthetist a bit because he was doing checks to see what I could feel. And because I knew that he was going to be touching my feet or something - in my head, neurologically, I was like "I can feel it," and he's like "can you feel that?" sort of thing, and I was like "I don't know! Maybe?" (Carrie)*

To administer the spinal anaesthetic, usually, a local anaesthetic is initially put into the skin of the woman's back, for which the woman might experience mild stinging pain, which numbs the area where the main spinal epidural is injected (Wilson & Douglas, 2016). Within a few minutes, the numbness should take effect. Touch and temperature tests are done on the woman's lower body to ensure that the anaesthetics have taken effect, and the woman is unable to feel any further pain (Anim-Somuah, Smyth, Cyna, & Cuthbert, 2018; Hashimoto, Kojima, Kitagawa, & Matsuura, 2020; Parikh & Seetharamaiah, 2018). Though uncommon that patients would feel incision pain during surgery after an anaesthetic injection, the experience can be traumatising for many women (Maheshwari & Ismail, 2015). Some women found communication with the anaesthetist and surgeon reassuring:

> *The anaesthetist, there were a couple of them, just kept saying "Tell us if you feel unwell." And our obstetrician was "This is what I'm doing," and she had a student - which was good for me because I like to know what's going on, and because she had a student with her, she was going and telling him the whole process that she was doing, and that sort of putting me a bit at ease. Because you can't see anything, and for me, that was a good thing. The same thing with the epidural, the anaesthetist had a student, and just talking through everything was the best thing for me. (Jane)*

General anaesthesia in obstetric surgery involves putting the woman into a medical-induced state of controlled consciousness, limiting her active awareness of the birth and discouraging any form of interaction (Anderson et al., 2004). Regional anaesthesia (such as epidural and spinal anaesthetic) is, therefore, a preferred choice. Women have reported feeling a sense of

security and control from being awake while undergoing surgical delivery (Ying, Levy, Shan, Hung, & Wah, 2001). Yet, being awake during surgery can also come with the anxiety and fear of the regional block not working or that instruments could be left inside them (Jlala, Bedforth, & Hardman, 2010). A few participants feared the operating team might leave surgical instruments inside their bodies after the operation raised anxiety levels. Some participants described feeling apprehensive on hearing the medical team count the items used for the surgery:

> *I heard them counting out all of the instruments that they used. I don't know they kind of freaked me out even more because it reminded me of the possibility that they might leave something inside me. (Debbie)*

A similar experience was also shared by Mary:

> *I remember thinking and being scared that they'd leave something in there and I was like oh my gosh I hope they don't leave anything in there because I've heard stories of people that I know that had happened and I'm like oh my gosh! That was pretty scary.*

Women's views also extended to their positioning during the operation. Some women felt that laying straight on their back with both hands stretched wide apart like a cross and not moving was a discomforting and distressing position to give birth. Gail described her experience of feeling uncomfortable. The restrictions on her body made her felt exposed and vulnerable:

> *I found it really vulnerable being unable to move and being naked basically on a table and they stretch your arms out so that they can get to your veins I assume, which isn't a very comforting pose to be in. It would be nicer if you could snuggle out kind of hide away from everything, but you're there, exposed to everybody and that was hard being in that position. (Gail)*

Gail's expression of vulnerability ties to her experience of an unplanned CS and the physical restrictions associated with the birthing process. Further highlighting the sense of discomfort at the caesarean section, more participants noted that feeling confined to a small space

(operating bed) and the inability to move or change positions made them "uncomfortable" (Scarlet). The freedom of movement during labour and the choice to assume different bodily positions in childbirth have both cultural and psychosocial benefits to a birthing mother, fostering a positive birth experience (Shilling, Romano, & DiFranco, 2007). Limited movement and static positioning have is a discomforting experience for many women during caesarean operation (Declercq, Sakala, Corry, & Applebaum, 2007). While women cannot move around during a caesarean operation, the contrast between what might be a normal active birth and the stationary nature of a caesarean section has implications on women's perception of their birth experience (Declercq et al., 2007; Shilling et al., 2007).

Interestingly, Gail's notion of being "exposed" opens up a recognisable, though non-conventional, concern for privacy in the delivery room (Guittier et al., 2014). For an emergency caesarean delivery, the number of professionals in the operating theatre - many the woman has never seen before - is commonly as high as ten due to the high-risk nature of the birth (RANZCOG, 2016). Most participants reported having between 10 to 15 people present in their delivery room, "So my partner was there, and our midwife was there and about 10 or 12 other people, I think" (Carrie). Most women want their childbirth to be private and prefer to birth in an environment where familiarity and control are most assured (Abel & Kearns, 1991; Guittier et al., 2014; Kuo, 2005).

6.3.1. Perceptions of hospital staff

Speaking on satisfaction with the hospital team, most participants believed that the attitude and professionalism of the medical team were "great" (Mae) and the quality of care they received was "amazing" (Kate). The majority of the participants believed that they were well

cared for by the medical team, and they were particular about the supportive attitudes of nurses and midwives:

> *I think the hospital staff was fantastic. The midwife that looked after us during the day, she was amazing. She was really good, she looked after us really well. They sort of let my partner stay longer than was allowed and sort of bent the rules a little bit, so that was nice. (Carrie)*
>
> *Everyone was so good, especially the nurses in NICU, they just did everything to try and help you out and it was like they weren't just there for the baby, they were there for you and the baby. (Paige)*

A commonly shared view among women was that the medical team delivered excellent care before and during the caesarean operation. However, they noticed a drop in this quality after they were transferred to their recovery rooms. However, one participant (Feh) recounting her experience with her surgeon in the operating room spoke of disregarding her feelings and not being adequately informed of the nature of care provided to her. In her view, the "bedside manners" of the lead surgeon was far from "compassionate", and she felt disrespected and medically abused when her body was used as an "object" for surgical training without her consent:

> *It was interesting being talked about like an object rather than telling me what's going on. They didn't even tell me when my baby was born, I had to specifically ask… And I didn't have that the first time with my baby, so that was a bit disappointing…We were listening to the things that they were saying and thinking "Have you forgotten that we're actually here?" From what I can recall, it was a senior surgeon and a junior and I think what was happening was that the junior was practicing suturing up the wound - which I was a bit peeved that I hadn't been told was going to be happening in the first place. I think it's only right to say actually, 'we're going to have someone that's going to be learning, is that okay with you?' So I was able to hear that back and forth 'I hope you don't stuff this up'.*

Previous studies have described experiences of disrespect and abuse of women during childbirth linked to care providers' interactions and actions (Lambert, Etsane, Bergh, Pattinson, & van den Broek, 2018; Reed et al., 2017). Feh's experience shares some similarities in the literature on women's perception of mistreatment during childbirth

(Hameed & Avan, 2018). Some form of obstetric violence includes physical and psychological abuse (Shabot, 2016), denial of quality care (Miller et al., 2003), a health system culture of constraints and restrictions (Jomeen & Redshaw, 2013), non-consented treatment (Reed et al., 2017) and, non-dignified and verbal forms of abuse (Ishola, Owolabi, & Filippi, 2017). One participant (Vic) further highlighted her perceptions of improper and inadequate care in her encounters:

> *The doctors didn't believe me that I was unwell. They took me off the intravenous drip twice too early, then they had to put it again. I had it go from here to here, to here like how many times. It was ridiculous! They took me off in the drip and I started getting sick really bad again so I think for them to take me off they must have thought I was somewhere I wasn't. I think like when they were stuck with what was wrong they kind of got annoyed. We even overheard them saying "do you think she's telling the truth"? Also, they said something like "the dark one" which my friend overheard and got really offended by. She went and talked to them about that, and that was a doctor talking to the nurse or the midwife about me.*

Though studies have attempted to appropriately define the phenomenon of abuse and mistreatment (Freedman & Kruk, 2014a, 2014b), the challenge remains the lack of consensus in the literature on how it is defined and measured (Hameed & Avan, 2018). In recent times, obstetric violence' is a common term used to describe women's experience of disrespect, abuse, and mistreatment during childbirth (Kukura, 2018). Incidents of mistreatment in childbirth are often culturally mediated and manifested in a range of sociocultural and geopolitical contexts (Chadwick, 2017; Jardim & Modena, 2018). These incidents are, in most cases, embedded within an existing power dynamic between the provider and the woman (Vacaflor, 2016).

Women's rights to respectful treatment are fundamental to quality maternity care (Ishola et al., 2017). Globally, the call for ethical standards regarding women's rights during childbirth has seen health systems develop strategies and clear policies that go beyond the prevention of maternal deaths and morbidities to ensuring respect for the dignity and inalienable rights of

women (WHO, 2011a, 2015b). The New Zealand *Code of Health and Disability Services Consumers' Rights Regulation – Health and Disability Commissioner Act 1994* (HDC, 2019) establishes the legal status for respecting and promoting women's rights during pregnancy and birth. These rights include her right to informed consent, right to refusal of care, the right to receive quality and safe maternity care free of harm and discrimination, the right to be treated with dignity, and to exercise autonomy and choice in her care (HDC, 2019). However, health care providers can still use the authority embedded in the health system and their professional hierarchy to legitimise their control over women's bodies and their own choice of appropriate care during childbirth. While this may not necessarily be problematic in certain contexts, it may however, leave room for non-consented clinical care during childbirth, and impact on the quality of care women receive.

Health workforce literature has demonstrated that health professionals are subject to high, though declining, levels of trust among the public (Collier, 2012; Shaya et al., 2019; Ward, 2017). Historically, the doctor-patient relationship has been viewed as imbalanced and paternalistic, which was profession-centred due to the acceptance of class structures and expert knowledge (Kaba & Sooriakumaran, 2007). More recently, however, a more patient-centred model has been advocated where shared decision-making is achieved through dialogue, therapeutic and reflective engagement, that fosters safe constructive space where the childbearing woman can express her agency (Anderson, Wescom, & Carlos, 2016; Emerson, Paquet, Sangha, & Robison, 2019; Kaba & Sooriakumaran, 2007; Klassa, Dendrinos, Penn, & Radke, 2016).

Summary

Caesarean birth experience challenges women's preconceptions of childbirth. Most women believe that an unplanned CS takes away from them their bodily agency. Women predominantly described the caesarean room as a place of fear and uncertainty, feeding into the sense of anxiety about surgical birth. There were mixed reactions observed among women about intraoperative awareness during the caesarean operation linked to regional anaesthesia. Most participants preferred to interact with their partners and care providers, fostering a sense of safety and companionship. However, for few participants, being awake and observing the 'drama' triggered general operative anxiety.

6.4. Theme 4: The affective responses of separation after birth

Childbirth experience can be intense and transformative and manifest differently (Olza et al., 2018). The goal of emergency obstetric care in childbirth is to manage risk and ensure the woman's safety and her newborn (Ameh, Mdegela, White, & Van Den Broek, 2019). However, understanding the psychosocial impact of birth on women's well-being is also essential (Benton et al., 2019). Maternal satisfaction with childbirth experience, the mother-infant relationship, including bonding and attachment, psychological well-being is affected by the mother's birth experience in the short- and long-term and are critical aspects of safe and quality maternity care (Clement, 2001). The previous theme narrated the subjective and shared views of the participants about their everyday experience of CS. This theme explores the participants' affective responses to maternal-infant separation and the impact on expectations of mother-baby interaction immediately after birth.

6.4.1. The notion of detachment from infant

None of the women interviewed reported having their newborns placed on them for skin-to-skin contact immediately (in the first minute) after birth. Separation and the lack of skin to skin was for most women "the hardest part" (Carrie) of their childbirth experience. For example, Debbie shared her experience of the times immediately after her birth and the moment of separation:

> *He was taken over to an observation table and I couldn't see him. My partner went over but they didn't lift him and show me or anything, they just took him straight away and I didn't get to cuddle him until they were moving us into recovery…I remember thinking that I wished that they had given him straight to me and then I didn't care if he was covered in blood that I wanted to…I wanted him to be where I was and I also remember thinking it was really important to get him breastfeeding as soon as possible. (Debbie)*

The separation of a mother and her infant dates back to the early 20th century when childbirth moved from home to hospitals, coinciding with increased use of general anaesthesia for pain relief (Anderson, Radjenovic, Chiu, Conlon, & Lane, 2004). Early skin-to-skin practice after birth has well-documented benefits to a newborn and the mother. Experts recommend that newborns get immediate contact with their mothers while still naked or only partially clothed to meet both physiological and affective needs of the mother and her child (Crenshaw, 2014; Stevens, Schmied, Burns, & Dahlen, 2014). Debbie's experience is common among women who deliver by unplanned caesarean section, as standard care routine often hinders this process (Hung & Berg, 2011; Taylor-Miller, 2010). A common reason for early mother-infant separation after a caesarean delivery is that newborns after operative deliveries are vulnerable to respiratory difficulties and often need to be supported to start breathing (Baumert, Fiala, Walencka, Paprotny, & Sypniewska, 2012; Berthelot-Ricou et al., 2013; Li, Zhang, & Zhang, 2019).

Concerns for alertness and responsiveness of the mother who may still be under the effect of the anaesthetics can also affect the decision to offer immediate mother-infant contact (Stevens et al., 2014). Some participants in the study described delayed alertness after their caesarean birth and used phrases such as "drugged up" (Susie) from medication, "so tired and sleepy" (Nicole) or feeling dizzy due to acute haemorrhage. The participants' ability to recollect the first moments after the delivery was impacted, and they were unsure if having the skin-to-skin then would have made much of a difference to them:

> *…that's something that really affected my whole experience because I was so tired and those really special moments with your new baby, I missed out on because I was so drugged and so tired. (Lucy)*
>
> *I was so out of it from losing so much blood, I wasn't upset or sad because I didn't get the chance to feel that because so much was happening, and I was so tired and sleepy. (Nicole)*

In Carrie's account below, she described the profound effect of being unable to hold her new child for what, in other circumstances, might be considered a short period. Feeling disempowered and unable to move from her position, she described her disappointment as having to wait until others decided that it was time for her to meet her child:

> *The hardest part, I think, was being so far away from your child…I think that was really hard because then there was a good five minutes or so before I even got to touch her, and it was like - you see all those pictures of women that get their babies straight away, but I didn't have that experience. I think that's a really big - something that you reflect on. (Carrie)*

None of the women interviewed reported having their infants placed on them before the clinical evaluation. The period of mother-infant separation was challenging to measure. However, some women suggested that separation lasted "very shortly, like five minutes, cleaned her up and cut the cord and just folded her up" (Eve). However, for other participants, the separation lasted between 24-48 hours after birth. Their newborns were transferred to an intensive care unit (ICU) for additional care for these women. An experience

reported in other studies (Gathwala & Narayanan, 1991a, 1991b; Rowe-Murray & Fisher, 2001).

> *I didn't see him for 24 hours. I was in recovery for so long because I lost so much blood. He was taken out, put straight into an incubator, and then whisked up to NICU. (Nicole)*
>
> *She was in intensive care in NICU. I didn't see her that first time until 48 hours later. (Olivia)*

Other participants shared similar outcomes. Phoebe's experience of separation was due to her child being preterm – "I didn't get to hold him for twelve hours…he was premature, he managed to just slip into thirty-five weeks". Similarly, some participants reported cases of neonatal respiratory dysfunction and other maternal complications – "He was not breathing very well, and I also had some sort of allergic reaction, and I was puffy and itchy and not very with it" (Ellen). Some participants felt that the separation was unnecessary as their child's clinical evaluation could have taken place after the initial brief skin-to-skin contact or while the baby was on them. These views tie to the birth discourses women felt they were exposed to during antenatal classes: babies are placed on mothers immediately after delivery. However, this was a different experience for most of the women as identified by some participants:

> *You are told you will have your baby, you can have your baby straight away, you can have her for 5 minutes, but I didn't get her, I got a quick hello, but that was it, until sort of recovery. (Caroline)*
>
> *I don't know why but I thought they might have given him straight to me to cuddle and then take him away to clean him up. (Debbie)*

Caroline and Debbie articulate the value women attached to their initial contact with their infants immediately after birth. It was clear that the women had preconceived expectations and views of early skin-to-skin contact as their first moments of motherhood. The physical separation was a barrier to 'a special moment' they had imagined would follow the delivery

for some participants. Despite these participants showing a clear understanding of the importance and the need for clinical evaluation of their newborns, most participants believed that having skin-to-skin immediately after the delivery should not have been compromised. Highlighting that women's expectations are critical, and how they perceive these are important and linked to outcomes. One participant who was unconscious for over five hours believed that her child should have been placed on her chest immediately after birth, even while she was out from the general anaesthetic (used in her case due to significant complications before the caesarean section). She spoke of her fears of possibly losing the primal connection with her child, believing that the contact should have happened whether she was conscious or not:

> *I woke up five hours later, I hadn't had skin-to-skin and I thought we wouldn't bond, which was a huge, huge thing for me. I wish they'd even put him on my chest while I was out. (Stella)*

Stella's quote articulates an element of the scientific. Her thoughts suggest her belief in initial physical contact as a precursor to emotional connection. The threat of separation could deprive her and her child of the assurance of attachment. Early researchers of mother-infant affective bond identified that early contact between a mother and her newborn facilitates cementing their affection (Klaus & Kennell, 1976a; Oliver & Oliver, 1978; Stern, 1977). Despite evidence of benefits of skin-to-skin contact immediately after birth (Stevens et al., 2014), post-operative surgical rituals after caesarean deliveries, particularly in emergencies, remains a barrier (Schorn et al., 2015; Smith et al., 2008, pg. 1037). For women in this study, their separation – whether minutes or days – resulted in expressions of "worry", "fear", "anxiety", "disappointment", and a sense of "detachment". Early skin to skin contact between a mother and her newborn immediately after birth lowers postnatal anxiety, stress and depressive symptoms following traumatic childbirth (Bigelow, Power, Maclellan-Peters,

Alex, & Mcdonald, 2012; Cooijmans, Beijers, Rovers, & de Weerth, 2017). The mother's first contact with her child, with no clothing in-between them, can stimulate a surge of hormones that facilitates physiological functions, such as milk production, and high breastfeeding self-efficacy, and fosters emotional bonding (Aghdas, Talat, & Sepideh, 2014).

Summary

Most women believed that having a caesarean section affected the immediate skin-to-skin contact with their newborns after delivery, impacting the mother-infant bonding. The admission of a newborn into the NICU resulted in immense distress to women. Most participants experienced short to long time separation periods, though many reported being stable and responsive and expected to have had immediate skin-to-skin contact with their infants. These expectations were predetermined beliefs primarily constructed from the natural birth expectations. Longer separation time also increased anxiety for most mothers, and some mothers believed that this impacted the subsequent bonding difficulties with their infants in the early postnatal period. While skin to skin may sometimes be seen as secondary to clinical evaluation of the newborn immediately after birth, women consider this vital in their birth experience. They are more distressed if the separation extends longer.

6.5. Theme 5: Sitting with the sense of responsibility and feelings of failure

Recounting their birth experience and unmet expectations, women expressed feeling multiple layers of failure against a backdrop of missed responsibilities and obligations. Multiple participants shared feelings of guilt, suggesting that the failure of their natural birth could be

due to actions and inactions they had taken or failed to take. Therefore, a sense of responsibility and failure was commonly expressed by most participants. They felt that having an unplanned CS was due to an inadequacy on their part. For example, Adele felt that she struggled with recurring questions of "what ifs", representing her thoughts of not being an ideal expectant mother during her pregnancy, possibly exposing her child to the fate of not being born naturally:

> *Maybe if I'd done things differently I wouldn't have ended up there." I don't know, I guess everyone beats themselves up, but I was like, 'Maybe if I'd been more active in the third trimester then he wouldn't have been posterior and then he wouldn't have like, put himself in that position'...Like, who knows, I could have done everything right - and it's not like I did. I don't rationally think that I did stuff wrong necessarily, I just think that, well you always question if you'd done things differently maybe you'd get a different outcome. (Adele)*

According to Adele's narrative, there is a profound sense of expectation to prepare appropriately and 'do things right' in the prenatal period to ensure optimal outcomes during childbirth. Adele's view of possibly failing in being active, eating right, and checking all possible markers, shows her shouldering of the personal responsibility for her birth outcomes.

Some women linked past events and known health complications with their bodies to their birth outcomes. They also questioned the possibility of a different outcome in the future and alluded to feeling doubtful of their ability ever to birth naturally:

> *I feel that the reason I couldn't have a natural delivery probably won't change, I think it is probably a physical thing. Again, this is a hypothesis but I had a post-12 week termination in 2001, so I think the surgery they did at the time, my midwife said "yeah there was a bit of scar tissue from that surgery. That's not going to change. (Mae)*

The disruption to their planned birth and the experience of a significant surgical delivery affected many women's self-belief. Jane recounted her feeling of "disempowerment" and shared the belief of her destined role of motherhood via natural birth. In this narrative, the discourse of responsibility and duty is reinforced:

> *I was a bit upset about it, that I hadn't been able to do what I was designed to do. But yeah, I didn't really have the choice at the end of the day…I felt cheated, to be honest. It's not - you sort of feel a bit cheated that you've not been able to deliver naturally yeah, it's a weird feeling. (Jane)*

Jane's expression of a predetermined responsibility and the use of such a mechanised metaphor of "design" makes it difficult to circumvent the ideology of biological determinism in the feminist sex/gender debate (Macdonald, 2006). She expressed the uneasiness that illuminates the discourse of "motherhood as a natural state" (Douche, 2007, pg. 184). In essence, Jane's language use reflects the belief that motherhood is intrinsically biological rather than a product of socialisation (Rogus, 2003). However, this discourse conflicts with the feminist contention of 'biology as destiny', which feminist scholars believe only deepens the societal gender division and subordination of women (Douche, 2007; Grosz, 1994). Yet, there are certain biological realities in the birth discourse around women's natural and physical capacity to give birth and motherhood as an integral part of a woman's identity (Laney, Carruthers, Hall, & Anderson, 2014; Shelton & Johnson, 2006). For which Gould (1981) cited in Miller & Costello (2001, pg. 592) claimed that the "differences between women and men arise from inherited, inborn distinctions". The tradition of adopting the concept of 'biological reality' in describing childbirth as mainly a biological and natural event often discounts the value of women's experiences (Held, 1989), which is entirely parallel with feminist belief.

Janes' view also highlights her perception of what her body should do and how it should function. Historically, the mechanistic tendencies of women's bodies and childbirth have popularly been grounded within a rigid technocratic mindset (Macdonald, 2006). In many ways, it has informed mainstream western ideological conceptions of the woman's body as a tool for reproduction (Foucault, 1977; King, 2004). Jane's reflections can, therefore, is an absorption of the hegemony in body politics, whose dominant discourse of the female body

views its essence to be dependent on its reproductive abilities (Dame, 1996; Rodríguez, 2016).

Women's accounts reinforced natural birth discourses, and physiological birth was viewed as morally superior and the best outcome for a mother and child. CS was described as a 'failed natural birth', for which some women appeared convinced that their experience falls short to 'giving birth', because childbirth is defined in the act of 'pushing out', rather than 'cutting out' the baby:

> *I felt like I failed. You know I didn't push her out. It didn't work. (Caroline)*
>
> *I was initially very sad, very disappointed in myself…I felt as though I'd failed, I felt like I'd cheated. I felt as though I hadn't actually truly given birth (upset as she spoke) (Phoebe)*

In Phoebe's expressions, there is an illustration of 'emotional processing' of her experience and involves a conscious effort to replay, describe and link the emotions she experienced from her traumatic birth to her current interpretations (Wilkins, Baker, Bick, & Thomas, 2009). Appraisal of these emotions resulted in Phoebe's later construction of her feelings, which she reflected and expressed as emotions of sadness and disappointment.

Another way women reinforced their birth discourse was via the perception of the 'control of the labouring body'. Women's expression of control over their bodies often emerged in phrases such as, "my body wasn't doing the right things" (Lucy), "I had no control over my body" (Stella), and talking about their bodies as separate autonomous entities. Therefore, putting some distance between 'them-selves', and their bodies and conveying the lack of agency. The non-progress of labour was linked to the power and capacity of the labouring body to function and deliver as women expected. The sense of loss of control over the body led to a loss of bodily agency and embodiment. In the excerpt below, Eve shares her

experience of ‘her body choosing to function differently from her wish’, which in her view, was the cause of her failed labour:

> *Apparently, this thing with my cervix happened not just because of my daughter’s position but also because my body simply refused to go through it… I experienced contractions and my body did not like it at all. (Eve)*

Although Eve’s quote suggests that this was how what happened was explained to her, her notion that “my body simply refused” imbue the body with consciousness as a sentient being. For one participant, she spoke of an inner conflict of ‘thoughts’ and ‘being’ and how her inability to settle the rising tension between her body and mind became a possible barrier to her labour progress. Mary’s narrative below echoes Adele’s tendency (discussed earlier) to take responsibility for the outcome of her birth, in this case, due to her mental state:

> *I've already had a really suck-like labour process…I was really tired, I'd been put on things and had things to help with everything…Initially, I started thinking like am I doing this to myself? Am I the issue? Has my body stopped working because of some mental block I'm having?*

The nature of Mary’s conception of the relationship between her mental and physical state reinforces the philosophical discourse of ‘mind-body state’ (Descartes, Cottingham, Stoothoff, & Murdoch, 1984; Zepeda, 2016). Through their narratives that their bodies “stopped working” (Mary) and “simply refused to go through it” (Adele), women explained they could not engage with their labouring bodies implying the body acting independently of the ‘self’ (Descartes et al., 1984; Kripke, 1972; Melnyk, 2012). Though, analysing Mary’s narrative of conflicting physical and mental states suggest that this loss was not isolated to the domain of the body. Lupton and Schmied identified that this conception of mind and body control could affect “women’s sense of self as autonomous” (2013, pg. 829), which may suggest that women’s sense of loss of control during caesarean section does not stop at the body and involves a loss of emotions.

Summary

While the conceptualisation of a caesarean section as a loss of bodily autonomy was pervasive among the participants, the current data showed that women's experiences were often represented as a loss over the entire state of being. Thus, the sense of loss was not specific to bodily experience but also a loss of emotional control. This highlights the emotional trepidations of the experience of unplanned and emergency operative deliveries. For some women, the inability to control their affective response during labour was a source of regret and guilt as they looked for explanations for failing to progress to normal birth. Women's narratives highlight the importance of attaching to early connections from skin-to-skin after birth, mainly because of the meaning that they attach to this event on early bonding between the woman and her newborn.

6.6. Theme 6: "It is a major operation": Resistance to perceptions that caesarean section is an "easy way out"

The previous theme highlighted women's narratives of sitting with a sense of responsibility and feelings of failure from their inability to have a natural (vaginal) delivery. This theme describes women's sensitivity and feeling of obligation to deconstruct society's perception of caesarean delivery as the "easy way out" and unpacks the participants' affective responses to their birth experiences.

Most women felt compelled to defend and explain the seriousness and intensity of their caesarean section experience. Some participants felt that society often looks on women who

have had a caesarean section as taking the "easy way out" (Eve), with the implication being that they were not a 'good mother'. Participants expressed frustration that their reality of an operative delivery was experienced by them alone: "No one sees it as major surgery. No, no one does. It's amazing; society just thinks, 'Oh, you've given birth. Oh, yeah, a C-section, okay." (Olivia). Olivia's comments echoed the sentiments of other participants who described their difficult recovery from surgery:

> *It is a major operation you know. My stomach is still not back to normal because there is a massive cut through it. Unfortunately, they do think it's an easy way out. I don't think any form of birth is easy. You have this massive child inside your little belly and it has to come out one way or the other; both ways hurts. Both ways have their pros and cons. (Eve)*

Eve's comment points to common sense that the wider society views a caesarean section with a negative connotation of being a more effortless and safer option. In Jess' view, the irony of this is that many women who have a caesarean section also experience prolonged and painful labour:

> *Unless you had a caesarean, you don't actually realise and I think there's a lot of perception there that you know it's the 'easy way out' but what people don't actually stop and think about is actually the majority of women who end up with a caesarean haven't planned it, they've gone through the process of trying to have a natural birth and by the time you end up with a caesarean you're three days into it you're exhausted and then you're into a major surgery.*

Due to the 'routineness of surgery, the seriousness of the caesarean section may sometimes be under-appreciated. Nicole felt that this might be impacting the way people view caesarean section. Still, she stressed that the physiological impact of being in labour for an extended length of time before having the caesarean section makes the experience particularly "hard":

> *I don't think people realise that it's major surgery; I guess because there are so many elective caesareans, that people probably think it's an easy way to go. But having gone through entire labour, assuming you're going to have a vaginal birth and then ultimately ending up with a caesarean, both of them are hard. But I really don't think people realise when you have a caesarean, its major surgery. (Nicole)*

The ‘choice’ of an emergency caesarean is neither straightforward nor easy. At every opportunity, women felt compelled to correct this inaccuracy. Jess narrated the sense of responsibility she felt defending herself and her decision, explaining that the choice was not hers to make but one that had to happen because “we weren’t getting anywhere”. She goes on to say:

> *First of all, I want people to know it wasn’t my choice because I felt like initially, people would be judging you that I ended up with a caesarean. But as soon as I said that it was unplanned, I felt like, actually, I always felt like I had to say it was unplanned, like “it was unplanned”!*

In addition to feeling the need to justify her choice, Jess also felt that highlighting the unplanned nature of her caesarean birth experience maintained her social status amongst her peers. Her narrative suggests a tension between women who have a caesarean section and those who give birth vaginally:

> *When she was born, the post that was put up on Facebook was that “it was unplanned caesarean” you know. My husband did it because I think you know like we read other people’s baby things you know. He just said “she was born via an emergency caesarean section”, that’s what he put on Facebook. I think I was pleased that he did it because I didn’t want people thinking I’ve chosen to have a planned one. (Jess)*

The impulse in women’s effort to defend themselves against stigma also stems from the famous label by the media and tabloids of women who choose to have an elective caesarean section as being “too posh to push” (Ramachandrappa & Jain, 2008; Taylor-Miller, 2010; Tully & Ball, 2013). It was complicated for Kourtney to carry the ‘extra baggage’ of being a midwife undergoing a caesarean section. She felt like she lost her right to privacy birthing in the hospital and, as a professional whose practice is grounded on promoting natural birth, she felt the need to protect herself from the anticipated stigma – from colleagues and the larger society:

> *You know when I entered the hospital, I knew that I would know everyone there as well which makes a very different experience…from a home birth…where for privacy reasons, you only have who you want there caring for you as opposed to the whole world knowing what's happening to you. It's meant to be a private thing but it's not because everyone that enters the room knows exactly who you are, so it changes things for you… I opted for an alias when I went into the hospital so that on the handover room my name wouldn't be with all my personal details as it is, so that wasn't my name, so unless people were in the room they wouldn't know that it was me. (Kourtney)*

Kourtney's decision to use an alias can be viewed as her 'sensitivity' to her privacy and her need to maintain her professional identity and credibility. The deviation of her birth seemed emotionally antagonistic to her beliefs. Although, on reflection, she felt that her experience had impacted her perception of a caesarean section and the way that she practices:

> *I think it does affect my reflections now on it, it does affect the way that I think about it you know; how a woman would think of me and my job as well because often people will ask you 'have you got children?' And up to this point, I didn't so it never was an applicable thing to their scenario. Now it is [banged table with a fist for emphasis]! So they'll ask 'what happened to me in my live birth?' Obviously, a planned home birth and I had a caesarean section which also I think makes me angry because people see home birth as a dangerous thing and so it kind of pisses me off that now I have to say that 'I wound up having a caesarean section after a planned home birth' because that is exactly what people expect. After all, in our practice, we champion normal birth…So now I feel like I'm kind of a fraud. (Kourtney)*

Though Kourtney's experience does not necessarily undermine her ideology, rationalising her narratives reinforces the reality that she may have to share with her clients that her birth experience contradicts the birth narrative she wants to support in her practice. There is currently a lack of evidence on midwives' embodied experiences of unplanned caesarean sections. In this context, the focus has remained on their perceptions and experiences caring and supporting women who require a transfer to an obstetric care setting (Grigg, Tracy, Tracy, et al., 2015; Torigoe, Shorten, Yoshida, & Shorten, 2016; Van-Stenus, Gotink, Boere-Boonekamp, Sools, & Need, 2017). Kourtney's experience, therefore, appears novel and calls for further research in this area.

Summary

The notion of caesarean section as ”the easy way out” was resisted by most participants, who felt that such assumptions fail to recognise the traumatic experience associated with a caesarean, particularly when unplanned. By actively asserting their views of emergency caesarean section as the worst of both worlds, the participants emphasised that caesarean section is a major surgery, often experienced after a lengthy and painful period of labouring.

6.7. Theme 7: “Most other surgeries you do have one”: The expectation of post-surgical follow-up after a caesarean section

The previous theme described women’s resistance to the notion that caesarean section is an easy way out of the pain of vaginal birth. In this theme, participants narrated their expectations and disappointment of the lack of post-discharge obstetric follow-up as part of their postnatal care. Predominantly, most participants felt that post-operative follow-up with the obstetric specialist should be part of their care after their caesarean section. While some of the participants expected that they would see their doctors who operated on them while in the hospital, the majority said that they wanted a post-discharge follow-up weeks later. Reasons for women’s expectations for post-surgical debrief included an opportunity for the woman to ask questions about their surgery and implications for future birth. Paige and Mae below narrated their views about their expectations and their experience:

> *I didn't get much of a debriefing afterward it was more just kind of a “hey you’re sown [sic] up let's get you onto the other bed, let's get you into recovery”. So the surgeon is more just there for the surgery part of it. (Paige)*

> *The surgeon is the only person who knows what they’ve done, what they’ve seen…You don’t get the opportunity to ask questions because you don’t get a surgical follow-up, so you are in the dark. (Mae)*

Among the participants, only two had an obstetric LMC. These women had privately contracted the obstetricians; thus, they reported seeing their obstetricians weeks after their birth. All women under midwifery care except for one did not receive any form of post-discharge debrief from their operating doctors. However, six of the participants reported seeing a doctor while in their recovery room. Though they stated that this was for a snap discussion about their recovery:

> *The registrar popped in and said "how are you? How is the wound? How is it going? Don't have another baby for a year. Yep! See you later!" (Mae)*
>
> *I remember the surgeon coming past maybe a minute or two when I was in recovery and she said basically that it had gone well, that even though what happened had happened, it wouldn't prevent me from giving birth naturally if I wanted a second one, and that was sort of all she said. (Jess)*

For these participants, they believed that seeing the surgeon a day after the operation was welcomed. However, this may be too early for many women who may not be in the right frame to digest essential information as they are still coming to terms with the emergency of the unplanned caesarean section. Some women argued that this alone might not be considered effective post-operative follow-up in the long term:

> *Yeah, they all came in. But I was a little bit still early so I don't actually recall much of the conversation. I remember them standing there, but that was it. So they probably should leave that till a little bit later. (Anne)*

Only one participant (Nicole) reported being seen four weeks later. She said seeing her surgeon again as her son had complications and had to return to the hospital for another week after being in the emergency care unit for two weeks after birth:

> *Yes, he came up to see me, and then he also came up to the NICU to check on Flynn as well, which was really nice. Flynn was in NICU for two weeks, home for a week, then readmitted back to the hospital. So we had a debrief with him once Flynn was back out of the hospital, so maybe four weeks, just to discuss the whole process, because of what happened to Flynn. We had to discuss everything, so we had a full debrief with him then. (Nicole)*

Some participants expressed shock at the lack of post-surgical follow-up after an unplanned caesarean section, describing it as "weird" (Suz) and noted that for "*most other surgeries, you do have one"* (Mae). According to Suz, while women may be given a precis when discharged from the hospital, this cannot be substituted for a face-to-face debrief with the doctor. She further stated:

> *I do find it kind of weird how you never had like a post-op appointment or anything. There was never any going back in to talk about it or physio…you'd think that there'd be something like that that you would go to. But after six weeks even the midwife was just like, "Oh, yeah, you're done now, you are mended." But even like what physio techniques you can do and go back to the gym and that. When I went back to the gym after six weeks I didn't know what I could do and I couldn't do. Obviously, there was the paperwork but it would be good to speak to somebody, the surgeon, three months later, or something. (Suz)*

Some participants did not feel the need to discuss the reason for and outcome of their caesarean birth with the doctors and were satisfied with consulting with the midwife LMC. For two of the participants, they felt it was "unnecessary" (Scarlet) to go back to the surgeons, and this was not something that crossed their mind:

> *I didn't feel that I needed to debrief with anyone else apart from my LMC and my family. That was all that I really needed. It wasn't something that crossed my mind that I needed to get over the experience. I just needed my midwife and that was it really so that was that I found that enough for me if I didn't feel like I needed to go anywhere else for any support or anything yeah. (Kourtney)*

Though the view of psychological growth after perceived traumatic births is largely underreported (Sawyer, Ayers, Young, Bradley, & Smith, 2012), evidence shows that highly distressing events during childbirth can also promote a moderate degree of posttraumatic psychological growth for women. Particularly women with less fear of childbirth and higher resilience (Nishi & Usuda, 2017; Sawyer et al., 2012; Susan, Harris, Sawyer, Parfitt, & Ford, 2009). This may suggest why some women can cope better than others after distressing or traumatic events during childbirth (Nishi & Usuda, 2017). Yet, the impact of psychologically

distressing events during delivery on women can be profound (Benton et al., 2019; Taghizadeh et al., 2013). Though she was clear that she didn't need medical support, Kourtney's use of the phrase "to get over the experience" may suggest silent distress or curiosity that may be dimly perceived and easily missed amidst the excitement of the birth and the responsibilities attached to nurturing (Zauderer, 2009). We can infer that the suppression of feelings and the need to debrief can be a way to avoid the recollection of unfavourable thoughts or the sheer determination to exhibit resilience. Kourtney later mentioned that though she felt she needed to speak to someone, she was unsure that it necessarily had to be the surgeon or counsellor. In her words, "I just wanted to review the experience in the eyes of someone else that was there". By this, she alluded to the belief that someone there (in the operating room) also had the direct experience. Thus, they could affirm or verify based on the 'actual situation', compared to someone not present in the room. Kourtney's narratives reinforce the importance of a 'reality check' for her in the context of her unplanned caesarean birth and may imply a lack of confidence in her perception. Though Kourtney felt that her husband could have provided that listening ear, she was unsure of getting the answers that she wanted and the way she wanted them:

> *I suppose a lot of women would say their husbands aren't very open emotional kind of type of people (laughs), maybe not everyone. So I think the way that I wanted him to answer my questions or talk to me about it isn't always going to be the way that you're going to get. Whereas talking to another midwife who is also a woman, it was a different kind of debriefing and it comes from a different place as well you know. Whereas he (partner) was there supporting his wife to have a baby, she was there supporting another woman to have a baby from a professional sense. So it's just different. (Kourtney)*

Postnatal birth discussions are generally part of midwifery care (Weaver & Fryer, 2014). This provides a debriefing opportunity for a woman to discuss their experience with the midwife and clarify details or address unanswered questions. However, in the context of an unplanned CS, the dynamics of debrief may be challenging for the midwife. Some participants felt

uncertain about their information as they thought that caesarean section is outside the midwives' expertise and scope of practice. In their view, the information from their midwives was mainly from the "midwife's perspective" (Lucy). They felt that the doctors are better positioned to explain the medical issues that led to their unplanned caesarean section since the midwife could only hypothesise possible causes. Mae explains:

> *I did speak to my midwife about it, and we kind of discussed a few things and between her, and we kind of hypothesise the reason for it, but it is still a hypothesis, it could likely not be the case.*

Mae's view suggests that what the doctor sees and hypothesise is more 'objective' and accurate. Besides, midwives' hypothesis did not seem to offer a resolution for most women who felt they might never know why their birth went the way it did. It was evident that women understood the need for the caesarean section, as delivering a healthy baby was of utmost priority. However, most women were unable to articulate the cause of their failed labour clearly and felt that this might be a "mystery" that they may never unravel:

> *I think I'll never know essentially why it occurred but I know why I went with the caesarean section was ultimately to save his life but I don't think what caused it will ever be, potentially, that we'll ever get to the bottom of that. I think it's society. I think for women, we find that really difficult. Why? Why can't we know why? Like you know I think that gives people a lot of solace like when they lose babies and things like that and women and families want to know why this had happened. And we can often tell them and I think that's hard you know it's really hard to know that you've had an adverse outcome happen and you never going to know why that occurred. So we can always guess can't we? But we're probably never going to get 100 percent answer. Potentially only going forward and having another baby and seeing what happens with that experience. Will that solve or not solve the mystery? (Kourtney)*

The intent to make meaning of her adverse experience is evident in Kourtney's narrative amidst the prevailing obscurity and incoherence of her experience. In the absence of coherence, narratives offered a chance to rebuild the meaningfulness and construct of her phenomenological realities (Crossley, 2000).

The space for dialogue of women's birth experiences is often subject to the care provider's time limitation. Creating this space was viewed by women as a vital part of their knowledge production. For one participant, having access to obstetric follow-up for questions and clarifications of issues should be viewed from a health-right perspective:

> *I think because it is a surgery you should have more information, they should supply you with more information as to exactly what they have done, and you should have follow-up because they don't provide that and I think that should be part of your right to know exactly what had happened. I don't think many women know exactly what they have done, maybe some people don't want to know but I would, definitely. (Mae)*

Sociological research in the UK found that women reported better information regarding infection control, coping, and management skills after other surgeries than during their caesarean operation (Weckesser et al., 2019). Also, women are more likely to receive "mountains" of information after a sugeries such as hysterectomy compared to a CS (Hesse, Julich, Paul, Hahnenkamp, & Usichenko, 2018; Marcus et al., 2015; Weckesser et al., 2019, pg. 6). Similarly, in Redshaw and Hockley (2010), women reported receiving inadequate care after their caesarean operation, impacting their negative perception of caesarean section. Individual circumstances around post-surgical treatment, support, and care appear to affect women's subjective constructions of their caesarean section experience. Women who received individualised and precise information are more likely to feel that care providers are sensitive to their needs.

The busy tertiary system may be responsible for the doctor's inability to have proper debriefing processes with women post-discharge. One participant felt that "I think it's really…because they're all very busy as well" (Eve). Irrespective of that, the implication for lack of post-discharge medical review on their recovery remains significant for women:

> *You probably know how they do it, they do the three-morning surgeries - and I will have slotted in straight before the next two women that were coming in behind me. So I*

> *imagine that she was busy and it was just the nurses in recovery that I was speaking to. (Feh)*

A common view by most participants was that post-discharge debrief is vital for women, particularly for first-time mothers. Crucially, the opportunity to see the operative surgeon for debriefing when they feel a bit recovered from the emergency of their caesarean birth would have a better outcome. In their view, this could "impact on how you feel about having another baby" (Mae). Other participants espoused similar views:

> *It probably would have been good just to see the person that did it. Yeah, a couple of days later that would have been good so you can actually get over the whole, you know, the drama of things. (Sharon)*

> *I would like for anyone else that has a caesarean, I would hope that everybody will get to see the doctor after and have what happened explained and told really clearly what happened in the hospital, what you can control and what you can't and why you have been prescribed what you have and that you can ask for more. (Meg)*

Participants' responses emphasised their desire for post-surgical follow-up with doctors and how this could support them 'get over' the many reverberations from an emergency caesarean section experience. Most of the women earlier reported that they lacked awareness of the reasons for their unplanned caesarean section. Thus, this could provide an opportunity for closure and an understanding of the implications on their well-being.

Summary

The participants accounts support the understanding that continuity of care is an integral part of the childbirth experience, and it promotes women's satisfaction with their pregnancy and childbirth (Perdok et al., 2018). Women under midwifery care who have an unplanned and emergency caesarean section experience an abrupt change in their maternity care. This sudden change was distressing for many women who experienced a sense of abandonment

when their midwives were unable to be with them throughout their caesarean experience. It was evident that women who had their midwives with them during surgery felt more supported. However, despite the continuity of midwifery care after an unplanned and emergency caesarean section, women's narratives suggest that they desire follow-up consultations from operating surgeons in the postnatal period. Most women felt that debriefing with the doctor could help them manage their physical recovery better, support their emotional well-being, and potentially impact their future pregnancy options/decisions. There are currently no clear guidelines around doctors' postnatal debriefing support for women after unplanned and emergency caesarean section in New Zealand. This may suggest a continuity of care issues for these groups of women. Post-surgical debriefing between women and operating can improve outcomes for women.

6.8. Theme 8: Transitioning to motherhood and changing family dynamics

Childbirth brings about immense physical, psychological, and sociocultural changes. A positive childbirth experience can help a mother transition well into her mothering role and her relationship with her newborn. However, a negative and traumatic birth experience can result in overwhelming feelings of distress, fear, and worry that can affect the mother's well-being postnatally and impact negatively on her ability to stimulate an emotionally demanding relationship with her infant (Nishi & Usuda, 2017; Rodríguez-Almagro et al., 2019; Taghizadeh et al., 2013). The previous theme described women's expectations and disappointment with the lack of post-discharge obstetric follow-up in the postnatal period. This theme explains women's transitioning to motherhood from an unplanned and emergency caesarean section. The theme is discussed under four subordinate themes: 'mothering through

pain, ‘the challenge of breastfeeding and bonding with the newborn’, and ‘Impact on future pregnancy decision. Together, these themes highlight some of the reactions that arose from women’s views of attaining their mothering roles after an unplanned caesarean section.

6.8.1. The challenge of breastfeeding and bonding with the newborn

The periods after an emergency caesarean section can be an intense experience for many women. With mixed emotions, the new mother tries to process what she has experienced and tries to make sense of the experience of an unplanned caesarean section and the considerable recovery her body needs in the coming weeks and months. Only four participants said they had early breastfeeding. Two participants stated that they started expressing after they left the hospital. One participant believed that expressing milk in the late pregnancy period before her childbirth increased her milk production. She had good milk flow, and her baby latched early, which made her breastfeeding experience positive.

> *Feeding was perfectly fine, I had no issues of feeding whatsoever and bonding fine totally fine. I wouldn't say that it impacted on my experience at all except for I had hoped the first initial part of the bonding had been different [speaking about the delayed contact immediately after the birth]. But that didn't change the way that, I mean it's hard to say because you've never had a normal birth to know how it would change you. How it changes that experience for you but because I've got no one to compare it to. (Kourtney)*

Kourtney’s narratives highlight the importance mothers attached to their breastfeeding experience with their newborns. Like Kourtney, other women in the study talked about bonding while discussing breastfeeding. Some described their breastfeeding as a “really beautiful experience” (Lucy), and an essential element in the development of a special affective relationship with their infants:

> *He fed straight away. He was really good at feeding, and he was always a good feeder…I think it helped our bonding to have had skin to skin with him. It's kind of weird, you know when something gets cut out when something gets pulled out of you. Nice cuddles helped. (Ellen)*

However, the breastfeeding experience was for most women a "pretty poor, we had a lot of feeding issues" (Adele), "difficult" (Carrie), and "exhausting" (Fiona) experience for most women. According to these participants, low milk supply, the difficulty of their newborns latching, or having the ability to suck due to being preterm and inadequate lactation support in the hospital and at home were common obstacles that affected breastfeeding. Mae's narratives below exemplify the experience of some participants who had difficulty with their newborns:

> *I tried, and it wasn't working, and my milk didn't come in…Every time I would go to breastfeed him he would get upset because he didn't want to latch, and I would get anxiety because I couldn't latch him. So I thought that I couldn't feed him, I couldn't provide. (Stella)*

> *He didn't feed very well at all. He didn't have a great sucking. He had reflux but he wasn't sucking well, so we were syringe feeding him and still trying to breastfeed but it was not going very well for a while. I tried breastfeeding him but he just kept crying and screaming and I thought oh, this isn't what I imagined, no one said it was going to be like this. It was supposed to be you know like a bonding thing. (Mae)*

Most women had a common perception that being separated from their infants immediately after birth and the lack of skin to skin contact which followed contributed to some of the challenges they experienced establishing early attachment between them and their newborns (see theme four).

> *They were still doing a lot of monitoring on him and me, because there was a lot of discussion about whether I needed to go onto acute or up to the ward - because I had a big bleed when I was in theatre. it definitely impacted his ability to feed, because he's - so I express now, so he gets breastmilk but he doesn't latch, and that's four months down the track - so he is exclusively bottle fed with breastmilk. Which is quite a commitment, because you've basically going to double handle every feed for him - which is totally worthwhile to do, but I would've loved to be able to breastfeed, but he didn't latch. (Adele)*

The separation was further complicated for some women, with their infants being in the neonatal intensive care unit (NICU) for a more significant part of the first few days postpartum. The longer the separation time, the more likely a mother could not breastfeed their child long term. Surgery-related maternal complications such as pains, restricted mobility, and severe bleeding further complicated women's experience of breastfeeding:

> *No, it didn't happen. We tried; she didn't take to me, and I didn't know if it was because of the way my labour went, but my milk never actually came through, so we had to bottle feed pretty much right from the beginning. (Anne)*

> *He was in NICU for two weeks, so he wasn't allowed to leave NICU until he could latch properly. Because he was so swollen, he couldn't open his mouth. I got discharged from hospital maybe three or four days afterward, and then we came obviously into the NICU every day and we tried to breastfeed, probably from day two, but he just couldn't open his mouth. (Nicole)*

Maternal and neonatal health complications after a caesarean operation can be an obstacle to mother-infant contact after birth and can also complicate the mother's ability to initiate breastfeeding (Guala et al., 2017). Barriers such as pain sensation, limited mobility, and positioning difficulties in the early postnatal period can impact the woman's ability to successfully initiate and maintain breastfeeding, potentially impacting maternal-infant bonding and relationship (Tully & Ball, 2014). Jess described having close to four litres of fluid pumped through her body before her operation, resulting in a swollen body, impacting her milk supply her ability to lift her baby for a long while:

> *I felt really scared holding her when we did get home because my mobility was severely compromised from not being able to pick her up, not being able to move from the surgery. I had to pop her down on the ground stand up myself and then struggle to pick her up. So I mean, it was sort of directly related to the caesarean. (Jess)*

Early maternal and infant affective bonding is critical for continuous affiliate behaviours of newborns and has been found to activate mother-infant unique attachment and social relationship (Forti-Buratti et al., 2017a). Some participants felt that the difficulty they

experienced with breastfeeding early on might have impacted bonding with their newborns. Thus, they suggested that the bonding issues could be tied to them having an unplanned caesarean section:

> *I guess in hindsight the only thing that I did miss was the skin to skin which seems to be really good for the kind of attachment and bonding helpful in breastfeeding. I knew about it, I guess I kind of just forgot once the 'Caesar' was happening. So in hindsight that's one thing I guess I was a little bit sad that didn't happen, and they didn't offer it, I guess they were sort of 'right, ok, you're done, lower you off the table, next one'! (Mae)*

Some women felt that having early support from lactation consultants would make a lot of difference for them.

> *I think that kind of breastfeeding thing and having more support in the hospital would be good. They kind of expect you to be able to do it but if you can't, then… Yeah I reckon it would be good to be some more support with that for people. (Lily)*

Some women felt that "night staff are definitely better to help you" (Sharon). Others who received support from lactation consultants and their midwives reported a more positive experience with breastfeeding and dealing with the difficulty of milk flow and helping their newborns to latch properly:

> *We ended up only being able to feed her with the shield, and the hospital wanted to discharge me and I was like "I'm not going home until I've seen a lactation consultant because I can't feed my child." Then once she had come in and suggested trying with the shield, we were fine. I wish I'd been able to feed her sooner. I didn't like the putting it in a syringe, because it does take away some of that skin to skin time. We ended up having to give her a wee bit of formula in the hospital, which she was a bit sick with - it's not as soft on the tummy. I wish, right from the start, I'd been able to do that. But it wasn't for lack of trying. She never got it without a shield. (Jane)*

The pressure on women to breastfeed came at the cost of some family dynamics and confusion, as they were turned between initiating breastfeeding and ensuring that the baby gets some nutrition:

> *I didn't know what to do, but I remember pleading with him (husband) for us to give her some food like formula or something, but he really wanted me to try breastfeeding, and then the nurse came in and yelled at the both of us. She said she was practically 4kg's she needs milk. Aaarrgh!!! I just remember being yelled at and thinking, oh my gosh, look, I feel like such a bad person, like a first-time parent. I think she could have like gently told us, and I think she'd heard Lucy crying for a while and yeah I just…yeah.. (Mary)*

A similar view from Anne below highlights the dilemma of normalised expectations and women's struggle with the pressure from dominant breastfeeding discourses:

> *I know breastfeeding is best, but in the end, for us, peace of mind knowing a child is happy and fed is more important. And it was a lot of pressure. I was using a syringe, so they wouldn't introduce a bottle for her, because they didn't want anything foreign going into her mouth, because they wanted her to breast feed. But in the end she was hungry, so she needed a bottle, but they wouldn't let me use one, so I had to syringe milk into her mouth. She was still being fed, but it is what it is; just feed her. Or let me feed her. (Anne)*

Breastfeeding precipitates affective and emotional reactions. It influences maternal mood presentation, provides comfort, and facilitates maternal care for the infant (Boyer, 2018; Krol & Grossmann, 2018). Despite these attributes, unmet expectations around breastfeeding needs can also cause maternal distress. The tendency for this to cause an emotional disturbance between the mother and her infant is high (Borra, Iacovou, & Sevilla, 2015). The loss of control during childbirth can make a woman desperate to regain control in their postnatal period via breastfeeding (Coates et al., 2014). Women can, therefore, feel a sense of failure if, after a traumatic birth, they experience difficulty or struggle to initiate breastfeeding (McBride-Henry, 2010; Krol & Grossmann, 2018). This can cause further frustrations for the mother. She feels out of control, confused and disappointed for not meeting her maternal responsibilities. She expected breastfeeding to occur naturally. It is a process that should come easy to a mother. However, this was an experience that was far from her reality.

6.8.2. Mothering through pain

This subtheme presents women's experiences of 'mothering through pain' while dealing with the many recovery challenges from an emergency surgical birth. Women's narratives of the postnatal experience identified conflicting experiences of anxiety, resentment, confusion, exhaustion, joy, and resilience. Most participants experienced challenges of limited mobility, inability to lift or hold the infant and care for them the way they had expected. Incision pain and the fear of reopening the scar from the caesarean operation affected women's physical ability to care for their infants. This further complicated the women's emotional well-being and dampened their mothering experience.

Karen experienced severe post-caesarean section pain that limited her ability to move freely or even carry her child for close to six weeks. Her physical recovery was prolonged and affected the way she could nurture her son. She shared her thoughts struggling to care for him and described going through a challenging experience trying to avoid being resentful of her child:

> *I was in Christchurch [Hospital] for three days, I couldn't walk, and I was not allowed any pressure, so I wasn't allowed to hold my son. I wasn't allowed to do anything, because of how the surgery impacted on my insides. After three days in Christchurch Women's, I went to St George's Hospital and was there for ten days. They would have to hold him if I was breastfeeding, so I wasn't allowed to hold him, - which kind of sucked… Obviously, with that six weeks of me not being able to hold him, it did make it a little bit harder. Even though I couldn't hold him, he was always in the bassinet next to me, so I'd hold his hand. Now and again someone would hold him, so I could cuddle him. It did make me very upset that I couldn't do it, but because obviously he was my child, and I loved him, and I didn't want the feeling of resentment after what I'd been through; I made sure, because I didn't want that, I blocked that out, just to make sure I could love him like any other mother who bonded has. (Karen)*

It is important to note that Karen's 13-day hospital stay post-birth is anomalous, with three to five days post-caesarean the norm, depending on the mother and/or infant (National Women's Health, 2016; New Zealand Guidelines Group, 2004). While the birth of a child is

usually an exciting experience for most mothers, a traumatic experience from a surgical birth, such as an emergency CS can negatively impact women's perception of control during childbirth, as well as their postnatal wellbeing (Ayers, Jessop, Pike, Parfitt, & Ford, 2014; Guittier et al., 2014). Evidence also shows that this complicates maternal self-esteem and caregiving behaviours (Reisz, Jacobvitz, & George, 2015). After birth, a newborn presents many demanding expectations from the mother in terms of nurturing and emotional attachment, which some women found difficult due to complications from their caesarean operation (Coates et al., 2014; Jikijela, James, & Sonti, 2018; Quinlan, 2019). Karen's conscious coping strategy is highlighted in her comment "I blocked that out", as an active effort not to allow her distress to impact her relationship with her son negatively. Like Karen, most of the women in the study were first-time mothers and looked forward to performing their roles as new mothers. Karen's narratives illuminate the painful and distressing recovery from a caesarean section which some participants narrated:

> *Having a child to look after when you've just had a major operation is really, really hard, and physically draining. (Lucy)*

> *My mobility was severely compromised from not being able to pick her up, not being able to move from the surgery, I had to pop her down on the ground stand up myself and then struggle to pick her up. So I mean, it was sort of directly related to the caesarean that impacted my ability to bond with her…It was a really really painful recovery…I still get lasting pains in that area, (Jess)*

The participants appeared to rate their recovery progress mainly by pain cessation, care for their newborn, and physical mobility. In some cases, after-birth complications can make physical recovery more complex. Though, for one participant who had a previous caesarean birth, normalising the pain was a way to deal with it:

> *Physically, it wasn't so great, but I knew what to expect so that made it a bit easier than the first time. I looked like a puffer fish because I get a bit of oedema quite a bit for a few weeks there, so that wasn't ideal. I had trouble walking - not just from the*

> *scar, the wound - but also because my legs were twice the size so that was just not fun. (Feh)*

The physical restrictions also extended to women's self-care. Some women talked about the discomfort they felt due to the incision. Stella described her postnatal experience as a reflection of the trauma she experienced during her caesarean birth. Her child was transverse, and she needed a 'T' incision (RANZCOG, 2017a), which was "quite long" and resulted in a "massive wound". She felt physically drained for a long time, and her recovery was negatively impacted:

> *I spent quite a lot of time just sitting…It was a massive wound because it's quite long, and the T. It was quite a big cut, so it took a little longer…I was making sure my partner and my mum were having a look at the dressing all the time because the last thing I wanted was to be set back in my recovery. I was on a lot of pain killers, and that helped, and blood thinners - I don't know what that was for. So I found them to be really good. (Stella)*

Caesarean section can cause considerable postnatal sleep disturbances in women (Tzeng et al., 2015). Lack of sleep in the early postnatal period has been found to impact a mother's ability to nurture her newborn with potential short and long-term maternal and neonatal adverse outcomes (Quinlan, 2019). The majority of the women interviewed reported having sleep difficulties after their unplanned caesarean birth. For example, Fiona spoke about having an early struggle with parenting due to being sleep deprived, and she alluded to reaching a breaking point where she almost wanted to be away from her child to cope with what she described as "extremes of emotions":

> *There were definitely times where I wanted someone just to take him for 24 hours, so that I could sleep for 24 hours, but there was no way I would have allowed that to happen either, because I couldn't be separated from him. It's extremes of emotions; extremes of what you need as well, - you extremely need a lot of sleep, and you extremely need to be with your child 24/7. I don't think I've ever experienced something that's torn me in two quite so much - emotionally. (Fiona)*

Fiona's narrative mirrors the experience of other participants. The experience was "terrible and difficult" (Debbie), and the poor sleep quality was linked to several factors, including post-operative pain, inability to sleep at choice positions due to the abdominal wound and, the mother's response to nurturing needs of the newborn:

> *I'm a side sleeper I'm not a back sleeper. I wanted to be on my side you know, that got a bit more difficult. (Paige).*
>
> *It was hard getting in and out of bed. My son woke up every two to three hours for the first 5 - 6 months. He refused to be put down for the first six months, I had to carry him and he was always being held. We used to sleep holding him which I know you don't need to do. So that was hard. He still wakes up four or five times a night but we're kind of used to it now. (Phoebe)*

Added to the complications of dealing with pains, fatigue, restricted mobility (having to sleep at certain angles), and other surgery-related distress, women found

> *It was more of the first move of getting out of bed or a couch. Because you're going to move like you normally do, but it hurts, and you don't think about that before you do it. So you've already jumped up, and then you've got, 'Oh shit.' And then you've got to slow down again" (Susie).*
>
> *Not being able to have a deep sleep cycle for over six months is extremely exhausting, to the point where I'm surprised people don't go crazy. It really makes you value sleep. I think even when you are asleep, you don't sleep deeply, because you're so in tune with your child. (Fiona).*

Women who in the past struggled with sleeping felt they experienced no significant change in their sleep quality, "I didn't sleep very well before I had the surgery" (Ellen). However, they experienced more fatigue from caring for their child while struggling with their insufficient sleep. One participant (Caroline) traced a link between complicated sleep patterns and a caesarean operation. She reported that the stress of caring for a baby with colic and dealing with the complications from having an emergency surgical birth, her sleep disturbances were almost inevitable:

> *I didn't get any sleep for a long time. She got colic [at] two weeks which didn't help. But of course, especially at the hospital, I had so many fluids with the C-section, with the oxytocin, I think I had 6 litres of fluids in 24hours. I got really swollen, really swollen feet and with the scar, I couldn't get comfortable. So the first 3 days of labour I didn't sleep at all, and then the first week in the hospital I felt sleepy but she didn't really sleep because we had issues. In the first month, I hardly slept and that was hard. Again, how are you supposed to recover when you can't sleep and you have to look after a person and stay sane? No one warns you about that. (Caroline)*

Though sleep disruptions can be a common occurrence among new mothers in the early postnatal period (Creti et al., 2017), Caroline's experience reveals the broader physical and emotional landscape of traumatic birth experience and its impact on the postpartum quality of life. The visceral emotions from lack of sleep and increased stress are commonly associated with an emergency surgical birth (Glazener et al., 1995).

The experience of persistent mild to moderate and chronic pain around the incision and lower back area can result in poor sleep quality among women after caesarean section (Liu et al., 2013; Wang et al., 2018). In the current study, some women reported experiencing persistent severe pain postnatally, "I struggled with the pain, and that took me a long time to get over" (Jez), which impacted their sleep quality:

> *My scar healed well but my body's been quite sore. I got given six weeks' worth of needles to have for blood clotting. I'm obviously three weeks down, and that's actually quite painful now, so you have to have it in certain spots, and it's really sore. My stomach's quite sore from that. (Anne)*

> *I was on so many painkillers because I couldn't sleep because it was so painful, I had to get all this medication to make me sleep. (Karen)*

However, some women reported that they were satisfied with their pain management and were happy with the pain prescriptions that they received from the hospital:

> *They give you pretty good drugs after you've had a C-section…They prescribe you with pretty standard Tramadol for the first like - must be like two days after you've had it - and then they put you on codeine. So like, I didn't have a lot of pain or anything. (Adele)*

Though the experience of pain complicated women's ability to care for their newborns early on, some participants felt their sleep experiences were no different from those of most mothers with newborns. However, getting out of bed was slower and took more effort:

> *It was good, yeah I mean every couple of hours but it was what I sort of expected and I don't remember being as tired as what I am now, because you know she doesn't sleep through the night now and I'm a lot more tired now than when she was a newborn. For some reason, I don't know why but yeah. (Jez)*

> *I don't think it did, I think it was just the having to get up and feed the child that impacted it. I don't think the surgery did. It just meant when I did get up it was a lot slower. (Jane)*

Despite the physical trauma from their caesarean birth, a quarter of women interviewed reported that they had a good and quick recovery. Though for most of them, it was complex learning to restrict their activities to what their bodies could cope with:

> *I lost like over two litres of blood in the surgery and stuff, so I was quite tired the next day or two - but then you have a new-born so you're kind of tired anyway. But I got in trouble from the midwives at the hospital because I got out of bed too early and stuff because, I don't know, I needed to change the nappy on my baby so I just got up and did it. Then one of the midwives came in and was like, "You're a fool, so just get back in the bed," she was like, "Just ring your bell." Like, I was fine, I begged them to take the catheter out the next day so that I could go and have a shower and stuff. My midwife signed me off to drive at like three and a half weeks post-partum, so that was really good, because I definitely felt like I was trapped a little bit, and I like my independence. So that was good. (Adele)*

A similar view was shared by other participants, for example, Ellen's who stated that her recovery experience was faster than she had expected:

> *The physical recovery was actually quite quick; after about a week I was off painkillers and I was walking - so I walked to the car when I was transferred which I think was after, maybe it was after two nights, in the morning. And then I was walking around the hospital quite slowly. (Ellen)*

The experience of post-caesarean pain differed among the participants, though the majority of women reported experiencing moderate to severe pain, which impacted their ability to care for their infants. Women's perceptions of caesarean section recovery were mainly centred on

the experience or lack of pain and limited mobility. Similar findings were reported in Jikijela et al. (2018) and Weckesser et al. (2019), which focused on caesarean section experience. They found that women experience difficulty transitioning to motherhood and performing their mothering activities.

Women identified pain complications and the nurturing of their infants as the significant factors that affected their sleep patterns. Experiences of sleep disturbance and pain differed among the women. However, a general feeling of satisfaction was expressed by most women around pain management. These views are consistent with previous research that has reported that women who deliver by caesarean section suffer from more sleep deprivation and experience greater feelings of exhaustion compared to natural birth. This can impact physical and mental well-being, with negative implications for the nurturing of the newborn (Majzoobi, Majzoobi, Nazari-Pouya, Biglari, & Poorolajal, 2014; Torkan, Parsay, Lamyian, & Kazemnejad, 2009; Tzeng et al., 2015).

6.8.3. The newborn mother: Getting caught up with the expectations of motherhood while recovering from a major surgical birth

Evident in the discussions of women were the many expectations of transitioning to motherhood while coping with the challenge of a slow recovery from a major surgical birth. Adapting to the role of mothering for most first time mothers was more complicated than they had expected. Notwithstanding, most women had a harrowing experience with mixed emotions and a perceived lack of capacity to form an emotional connection with their infants irrespective of previous birth. In the excerpts below, the participants narrated their experience of ongoing disconnection with their infants as they struggled to balance their sense of self and

shift their mindset to becoming a mother and taking up their maternal roles and responsibilities. Stella talked about being a woman who loves to have control but felt unprepared for the lack of balance that followed her traumatic birth. She found bonding with her son postnatally to be an arduous task and felt that impacted her family dynamics negatively:

> *Mentally, I don't know, you've got a new baby, you're out of your depth, and you've just had your world thrown upside down. Mentally would have been, I think, the hardest thing. Physically I've heard it's really bad, but I think I was just caught up with everything else emotionally…I just wanted to start bonding with him. But it was hard, and it caused a bit of a rift in our family, just because not a lot of information was given, and everybody was in a very high-strung environment. It was hard, and it does make me really, really worried about doing it again. (Stella)*

Other participants shared a similar experience. For example, Karen reported that she felt this emotional tug-of-war for several weeks post-delivery. She had to come to terms with the emotional emanations which stem from the long periods of her hoping she could 'carry on' and eventually become the mother that wanted to be for her child:

> *In the beginning, it obviously affected me, because I couldn't mother my child. I had to expect other people to do it for me. In general, that was the most upsetting part of my birth, was the fact that I just couldn't be a mother. After I started healing, I decided I wanted to be the one to look after him, obviously, I couldn't do it on my own, but once I started being able to walk, I wanted people to help me be a mum. (Karen)*

An underlying peculiarity of women's accounts of their expectations as mothers reflected anticipation of a natural and intuitive knowledge of motherhood and mothering. The phenomenon of 'matrescence' has been used in recent times to articulate the ways women experience the transition from the known – "end of self", to the unknown – "the newborn mother" (Mercer, 2004; Thomas, 2001, pg. 94). According to Alexandra Sacks, to attain this new state of motherhood, the new mother becomes burdened by 'unrealistic expectations' of maintaining control, staying happy and developing whole and complete, undivided love and affection for her newborn (Sacks & Birndorf, 2019). In reality, new mothers experience body

morphing and hormonal surges after birth. Thus, while a new mother may be expected to have everything under control, she may be confronted by emotional instability, affective emptiness, and lack of an instinct to love, care and feel emotionally connected to her newborn in the early periods postpartum. Participant narratives describe an experience of "unwelcome beginning" (Coates, Ayers, & de Visser, 2014, pg. 4), reflected as a sense of emotional detachment from their infants and a concern for being unable to take up their maternal roles. This was an experience shared by most participants. This conflict of identity shift is a significant component of 'matrescence' (Mercer, 2004; Sacks & Birndorf, 2019; Thomas, 2001). Jane described her experience of unexplained emotional burst and her inability to regain control over her emotions:

> *I was an emotional wreck there wasn't like a specific reason why. I mean they call it – 'baby blues' – but it hit me really hard, and I think that sort of upset me more because I'm generally able, mostly, to control my emotions. I just couldn't - my Mum would say "How are you?" and I'd just burst into tears for literally no reason. (Jane)*

Women's ability and competence in performing their maternal responsibilities in terms of meeting the needs of their infants was indicative of their successful adjustment and transition to motherhood. The ability to exert control over their emergent identity and the task ahead as a new mother, expressed through self-pressure to meet constructed expectations, suggested an internalisation of maternal role attainment. The feeling of emotional detachment was an indication of a lack of control over their emotional stability. In Gail's narrative below, she described feeling disconnected from their child. She felt something was wrong inside of her as she was unable to reconcile her inability to measure up to her expectation of being a good mother:

> *I think I felt really negative about motherhood for quite some time. Yeah, I think I had a really negative experience of having a child, of giving birth, and the early days of being a mother. So it wasn't until she was probably about maybe four months or maybe six months that I actually felt like it was good being a mum and started to enjoy being a*

> *mother and basically because motherhood wasn't rewarding for a long time. It was really hard and difficult for a long time so it wasn't a great start, but she won me over with all the smiles, the cuteness, and the fun and the reward once it started coming I decided motherhood is okay. (Gail)*

Gail conveys a sense of loss, discontent, and lack of self-belief concerning the attainment of her maternal role. She expressed feelings of being incapable, overwhelmed, and uncertain about the enormity of her mothering responsibilities. The psychological impact of her unplanned caesarean birth appeared to go beyond the bounds of a transitory adjustment to motherhood or temporal mood changes (baby blues) (Quintero, 2014). Gail further cites her unease reconciling her emergent identity of being a mother with the prevailing assumptions and values suggesting motherhood should be easy or come naturally. Retrospectively, however, through her discovery of inner sensitivity, Gail challenges the myth of 'good motherhood' defined from her current state. As she reconnects emotionally with her child and new meanings of her experience are produced, she reflects a sense of appreciation, reward, and positive emotions that emerges from the contagious awe of her child's affective cues. This emotional transformation highlights other dimensions of self-empowerment and growth reportedly associated with motherhood and mothering, as women begin to experience both physical and emotional bonding attachment with their newborns (Athan & Miller, 2013).

Support for postnatal stress and anxiety were actively sought by many of the participants who felt they were developing post-traumatic reactions and found it difficult to cope on their own. Though midwife LMCs were the first point of contact in terms of professions in the postnatal period, some women felt that their midwives' support was mainly focused on babies:

> *Aftercare from my midwife's perspective…was more about the baby…It was maybe a month or so later that I really sort of I realised in myself that I wasn't coping. I was really lucky that even though I was on maternity leave, we could actually afford for me to go and see someone privately. So I went to this private psychologist for a sort of coping strategies for my anxiety and it was about 10 sessions that I went to, but it*

> *wasn't until I got to the other side, I mean I'm still struggling with my anxiety but I've got my coping strategies. (Jess)*

Jess's need for a private psychologist to support her postnatal anxiety was echoed by several participants, suggesting that government funding for mental and psychological support for women following traumatic birth experiences is inadequate. However, some women noted that they found support from online social media groups helpful, though they still struggle to cope mentally.

> *Mentally I'm still not there. I still have issues with it, like I have fought back a bit, that's why I'm on that Facebook group (Birth Trauma Support NZ). You know you are not with that Facebook group if you are sort of over it. It is quite a hard thing to get your head around, especially when you were expecting something else and it is so hard to recover from it physically and look after a person. You have had a major surgery, normally you will be resting and you can't, especially if you are on your own which I was, and there is no rest, which makes it so much worse. (Caroline)*

> *I used to think about it you know now and then and I remember having those flashbacks when [my daughter] turned one. There was one night when I went into the shower, I was having a shower and it reminded me of like being in the shower both at home and the hospital during the time, and I came out of the shower like afraid or scared (Mary)*

Though Mary did not report the clinical diagnosis of a depressive illness, her description of having flashbacks and post-traumatic symptoms a year is reflective of the long term implication of an unplanned CS. Evidence shows that traumatic caesarean birth experiences can have long-term implications on women's psychological well-being (Ayers et al., 2016; Lopez et al., 2017). Fiona below stressed the need for more support around obstetric and reproductive counselling services for women who experience traumatic birth:

> *I needed more mental support. I benefited well from counselling previously. I think that counselling is extremely underrated, and people are always scared of, but it's so valuable when you find the right person who can really help you to see and discover things for yourself, to make you see clarity in the world, and to see happiness, and feel it. I think it would have been really good to have had that in this last year - to have had a counsellor to emotionally support you. (Fiona)*

Family support enabled many of the women to pull through what appeared to be a problematic postnatal experience. Most women found their partners' ability to come on board and take over the sole carer role for them and their neonates outstanding. Despite most women being unhappy that partners only had two or fewer weeks of paid leave, they felt their partner's presence helped maintain responsiveness to the infant's care needs and welfare. Ellen's praise of her partner as a champion for her and the baby was typical of other participants' views:

> *He was really good at everything. He was amazing making sure that I was happy with everything that was happening, and talking through everything when I needed talking. He was always really supportive, and he's always been really vocal about the fact that he thinks that I did everything right and that he feels that… I don't know, because sometimes you hear that that's not a proper birth or whatever, but he's like "no, you gave them as proper a birth as they needed". (Ellen)*

The relationship between unplanned and emergency caesarean section experience and postnatal psychological reactions has been reported in the literature. Most women have reported feeling less satisfied with their birth experience following a caesarean section (Carquillat et al., 2016; Karlström, 2017). Postnatal depression is a common experience among women unsatisfied with their birth experience (Corrigan, Kwasky, & Groh, 2015; Sacks & Birndorf, 2019). Often their post-traumatic reactions can be normalised as expected hormonal responses after childbirth and the transition period to motherhood. However, research has found that women who undergo a caesarean section, especially when unplanned, are more likely to be depressed or experience anxiety in the postnatal period than women who birth vaginally (Benton et al., 2019; Fenwick et al., 2003a; Gamble & Creedy, 2005).

6.9. Theme 9: "I automatically get a caesarean": The constructions of choice and autonomy around future childbirth choices

In the previous theme, I described women's accounts of the difficulties they encountered around transitioning and taking up their roles and responsibilities of mothering while still recovering from a major surgical operation. This final theme highlights the participants' conceptualisations of their rights of choice and autonomy in decision-making for future pregnancy and childbirth, notably informed by self-negotiation and information from care providers.

Most of the participants felt their unplanned caesarean section experience had no impact on their intentions of having further children. These views are in contrast with previous studies that have reported a negative effect of caesarean section on fertility intentions and decreased desire for more children (Fussing-Clausen et al., 2014; Norberg & Pantano, 2016; Preis et al., 2020). The participants in this study noted that they were still motivated to have more children:

> *We are already planning for the next baby; super excited about that. (Lucy)*
>
> *We want to have another child because I want to have another child. (Stella)*
>
> *I definitely want to have more children, in fact, because the whole experience was so nice the day we got home we were lying in bed and I told my husband "I want another kid". (Eve)*

Eve's comment was against the backdrop of a challenging experience trying to have a natural birth. She spoke of her body refusing to go through labour contractions and felt depleted by the pain and exhaustion. Eve felt that things became "easier" after consenting to caesarean birth. She stated that due to her experience, she feels she can trust the care providers to manage her birth better next time "because I know that everyone is so competent; the

anaesthetists, the surgical team, the midwives are competent". This sense of trust in care providers appeared to make Eve less worried about her delivery method in her future birth. Instead, she was more focused on the decision of having another baby. This is significant as it draws attention to the importance of women's experiences with care providers and their intention and desire for more children after a previous caesarean section. Another participant spoke of her increased resolve to have more children despite her unsuccessful vaginal birth. She expressed that planning to have another child would allow her to better manage her birth, with the hope for a specific expected outcome:

> *I sometimes felt I was a bit rubbish but I didn't feel as [if] I couldn't do it. It certainly has not put me off having another child it hasn't put me off. If anything it's made me feel stronger about the prospect of having another one but it also has made me feel that I actually want to have another one just to have another go and to deal with it better. (Phoebe)*

Phoebe's relatable admission that she sometimes felt a "bit rubbish" as a mother contrasted with many of the more rigid expectations other participants placed on themselves as new mothers. Like Phoebe, other participants were focused on the future and did not appear weighed down by the difficult births or bonding experiences that followed their unplanned caesarean. Two women stated that they had no plans to get pregnant in the future. One of the participants pointed to age as a factor for her choice, while the other noted that she was advised due to potential medical complications:

> *I don't want another baby, because they told me, because there's so much scar tissue, and because it got all complicatedly wrong; they told me there's absolutely no chance that I will ever have a natural birth. After what I've been through with that caesarean, knowing that that will probably happen again. They told me that it could be potentially quite life-threatening if I have another child. (Karen)*

Views on the preferred birth method (repeat caesarean or VBAC) for future birth were diverse among women. While a small number of women did not choose their future birth method due to their complicated birth. The remaining participants were divided between

intending to have a repeat caesarean section, preferring a vaginal birth after caesarean, and being unsure of their future preference. Some participants expressed that due to their satisfaction with having a healthy baby, the quality of the care received during their caesarean delivery, and their trust in medical professionals, they would plan for an elective caesarean section for their next childbirth.

> *To be honest, if I was to have another child, I'd probably probably request an elective C-section next time around. I don't think I would try for a natural birth after it. I just feel too nervous. I mean I had a lot of time to think about what had happened and I even said that to my midwife. (Jess)*

Jess's narrative also suggests an element of fear of the possibility that her trial of labour might end up leading to another unplanned CS. Thus, to avoid the potential trauma of going through a similar experience, she believes that planning an elective caesarean would ensure that she exerts better control in her subsequent birth. Fear of trial of labour among women who had an unplanned CS can impact their choice of delivery mode in a future pregnancy. The interaction between fear and mode of delivery after previous caesarean delivery has previously been discussed by McGrath and Ray-Barruel (2009). Similar to the findings in this current study, the authors found that fear and the desire to maintain control in subsequent birth were the key factors driving the choice for an elective caesarean section among women who had a previous CS. The expectation of having more power when they plan for an elective CS in subsequent birth stems from the notion that there would be a total focus on the birth by the care providers next time around, which eliminates uncertainty.

Another participant (Carrie) stated that while she is willing to try a VBAC next time, her perception of CS has changed. Though she recognised that "it was stressful not being able to do much" during her recovery period, however, she felt that having a healthy baby and recovering well at the end assures her of a favourable outcome:

> *I think because recovery was so good and my child was super healthy, I wouldn't be averse to doing it again if need be. And I wouldn't be one of those - there are lots of Mums that they have a C-section and then they insist on having a natural birth and they go to the ends of the Earth to have it - but I'm not one of them. (Carrie)*

Carrie's view also highlights that the choice for an elective caesarean in subsequent birth for most women indicates their view of CS as a 'safe option' in childbirth. With the understanding that after a previous CS, women now know what to expect subsequently. This knowledge is vital in how they perceived risk and predicted future outcomes, as there is an awareness of what to expect subsequently due to their previous experience. According to McGrath and Ray-Barruel (2009), unlike their last experience, this "sense of the known" decreases women's anxiety about caesarean section in future pregnancy and childbirth (pg. 275).

Some women mentioned that they were informed in the hospital about birth choices for an elective caesarean section in a future pregnancy. This information was crucial in informing women's thoughts about future pregnancy decisions. Following a previous caesarean section, NZ women have a choice to pursue a further (elective) caesarean or vaginal birth after caesarean (VBAC) (CDHB Maternity Guideline, 2016). Knowing that they have access to a publicly-funded elective caesarean section informed women's plans and choices for future births. These participant's narrative also suggests an elective caesarean provided a sense of control over their future birth:

> *I automatically get the option to have a caesarean; once you've had one for whatever reason then you can automatically say next time right, as soon as you know that you're pregnant we are going to plan a caesarean. (Phoebe)*

> *I think I would have another C-section for the sheer fact that I can pretty much pick and choose a day. Now that I know how it works, it's fine. (Sharon)*

> *I've already asked and they've already agreed [talking about hospital staff], that I don't want to go through a vaginal birth again. I can book a date and I can have a C-section. And I do want to do that; I don't want to go through that again. (Olivia)*

Many women were emphatic about having a VBAC next time. According to Ellen, she believes that a child is "originally supposed to be born" vaginally and natural delivery remains the "best option" for both the mother and her child. Other participants held similar views. Kourtney and Susie, for example, shared their opinion on choosing a vaginal birth over having a planned caesarean next time:

> *I would do it again even knowing that the same thing would happen, I would still plan to home birth next time. My family's support and my midwife's skill, knowledge, and support would make me feel more than comfortable in doing this. However, I do think I will have anxieties about my next pregnancy around my labour and how it will turn out… I think it just adds further worry. (Kourtney)*

> *I would still choose a natural birth over a caesarean. I've got friends that went caesarean, caesarean, and because they've known no other way. But because I've had both, I'd choose natural any day. (Susie)*

Other (nine) participants felt conflicted at the choice for a repeat caesarean section and vaginal birth. In their view, they would instead seek the opinion of medical professionals, particularly obstetricians, to inform their choice next time around:

> *I'm still uncertain as to my best option. I think I'd want to talk to and take advice from my obstetrician and other people (Catherine)*

> *Obviously, because I've had a C-section now, I get the option to choose whether I'd have another C-section - like an elective one. I think I'd like to try and have a normal delivery, but also, I don't think I'd be black and white about it. I'd take the medical advice. (Adele)*

In Adele's excerpt, she shows a situation of pragmatism in her desire for normal birth. However, what was also clear was her resignation to medical experts' views and how this would influence her decision-making.

Reproductive rights were part of the critical issues of the feminist political movements (Coney, 1997). In recent times, the discourse of the right of the childbearing woman to decide what should happen to her body and choose how and where she wishes to give birth has been

the subject of much sociological literature (Romanis, 2019). Despite this view, the impact of women's ability to freely choose between having a planned caesarean section or vaginal birth after a previous caesarean delivery has been highlighted as an important factor contributing to global caesarean section rates (Gholami et al., 2014). Many have criticized the culture of a 'supply-driven model' for caesarean section (Begum et al., 2019; Lauer et al., 2010). Regardless of medical needs, women are encouraged to have caesarean section mainly due to a previous surgical birth because of the capacity of the health system to provide surgical, obstetric services to maternity consumers (Begum et al., 2019; Lauer et al., 2010).

Though some researchers claim women prefer to have a vaginal birth over a CS (Maznin & Creedy, 2012), recent studies suggest that given a choice, many women after an initial CS prefer a repeat CS (Begum et al., 2019; Crowther et al., 2012; Gholami et al., 2014; Shorten, Shorten, & Kennedy, 2014). The participants' narratives implied a sense of control could be gained from the decision to pursue an elective caesarean, providing a reprieve from what might otherwise be another difficult birth.

Clinical factors remain key in decision-making for a CS. However, attitudes of care providers, particularly obstetricians, are crucial in women's choices for repeat CS (Begum et al., 2019; Healy, Humphreys, & Kennedy, 2016b; Loke et al., 2019; Monari, Di Mario, Facchinetti, & Basevi, 2008; Panda, Begley, & Daly, 2018; Sahlin, Andolf, Edman, & Wiklund, 2017). This view further highlighted among participants in this current research who felt that the language used to describe their childbirth as risky and their unborn child in danger of dying influenced their decision.

Autonomy and choice are often said to reinforce each other mutually, and the freedom to choose is in itself an affirmation of the value of one's autonomy (Dan-Cohen, 1992).

Autonomy in childbirth also encompasses how women conceptualise how they use their bodies to actualise delivery (Burrow, 2012; Romanis, 2019). Within bioethical discourse, the concept of choice for women in pregnancy and childbirth is often perceived as underpinning and promoting birth autonomy (Kukla et al., 2009; Romanis, 2019). The basis for this view is that increasing birth choices for women, for example, offering routine planned caesarean, enables women to exercise their rights and make decisions that align with their sociocultural beliefs, value systems, and interests. However, this view that choice promotes autonomy has also been criticised (Thachuk, 2007). The information given to women by their care providers can sometimes be influenced by the provider's practice philosophy, ideological and theoretical limitations (Lothian, 2008a; Naylor Smith, Taylor, Shaw, Hewison, & Kenyon, 2018; Romanis, 2019; Thachuk, 2007). In such circumstances, women may make decisions that do not truly maximise their agency. Therefore their choice and decision-making are constrained by "relational autonomy" in the broader context, notably when the relationship with their care provider decreases their exercise of informed choice (O'Brien, Butler, & Casey, 2017; Thachuk, 2007, pg. 46). Often, in these ideological discourses, one voice that is missing is that of the woman. It is vital to redirect the focus back on the woman and ensure that discussions around her care are made within a transparent and relational space. Care providers should strive to ensure that meeting women's emotional and physical needs takes priority above individual professional ideologies. The conception of women's autonomy in childbirth should be far from problematic and contentious.

Chapter Summary

This chapter presented the findings from interviews with 30 mothers who had an unplanned and emergency caesarean section. From the analysis, an overarching theme, 'the mixed emotions of becoming a mother from an emergency caesarean birth,' captured women's experience of unplanned and emergency caesarean section and was reflected in the various interrelated themes. Women spoke about care providers' influence as an important factor in decision making. The narrative of safety for the unborn child was a common reason for the recommendation for an unplanned caesarean section. The disappointment that arose from not experiencing the birth participants they had planned and hoped for and the satisfaction of having a safe, healthy newborn influenced their conflicting reactions and subsequent relationship towards their infant, themselves and their family. As most participants had planned and expected a natural vaginal birth under midwifery care, the abrupt shift in care came as a shock for most women and caused significant distress. Most women were concerned about delayed contact with their newborns immediately after birth. Most women had a more extended stay in the hospital, and some suffered complications from their caesarean delivery and described this as a problematic experience. The incongruence in birth expectations and the outcome of caesarean birth made most women view their experience negatively in retrospect.

Resisting the perceptions that caesarean section is an easy way out, most participants felt that such an assumption does not reflect the seriousness and intensity of a caesarean section. In their view, this might explain why women are expected to 'get on' with their mothering responsibilities despite caesarean section being major surgery. Describing a sense of disappointment, most women felt they could not birth naturally as their bodies failed them. This caused feelings of guilt, failure, and loss. The sense of loss was commonly

conceptualised in terms of the loss of control of bodily experience and emotions and the other configurations of care that make up their childbirth experience. The transitioning to the mothering role was a challenging experience for most of the participants, as many needed to make many adjustments as they tried to balance their new emergent identity (of motherhood) and their sense of self. Difficulty establishing bonding and emotional attachment with their infants in the early postnatal period caused most women to internalise a sense of failure in their role attainment of motherhood. This suggests that for most women (especially first-time mothers), becoming a mother is an immense social change that is complicated by an unplanned and emergency caesarean section.

Adopting a poststructuralist view and understanding that changes in our experience of social relations fundamentally influence how we make meaning of reality highlighted the diversity and uniqueness of women's birth stories. Crucially, it emphasised the importance of focusing on research approaches that promote women's voices via discourse and understanding their lived experiences from their worldview. Therefore, this research has focused on valuing women's subjective experiences, a conscious turn from traditional oppressive and patriarchal approaches that suppress women's views and dictates how childbirth and mothering should be conceptualised. The next chapter discusses the study's findings and further addresses the themes identified as it relates to the study objectives and the research questions. The findings are further critiqued in relation to previous studies and end with my interpretation of the research findings.

Chapter Seven: Discussion

7.1. Introduction

This qualitative study explored the views of 30 women who had an unplanned and emergency caesarean section (CS) in Canterbury, New Zealand, as well as 11 lead maternity carers (LMCs) (obstetricians and midwives) working in the system. In-depth interviews were conducted with all participants, and the data from both groups (LMCs and women) were analysed separately using the Framework approach, thematic and discourse analysis. The study results have been examined in Chapters Five and Six; the present chapter seeks to make sense of the study findings, answering the research questions, and identify the contribution of the research to the field.

Informed by the literature review, the research questions were:

1. What are women's expectations of birth, and how do they compare with their experiences of unplanned caesarean section?
2. How do women's experiences of unplanned/emergency caesarean section impact their physical and emotional well-being and their transitioning to motherhood?
3. What are LMC's views and perceptions of intrapartum and postpartum care and support experienced by women who have unplanned and emergency CS within the NZ maternity system?

The first two research questions deal with expectations versus experience: the expectations of labour and birth, motherhood, and the postpartum period both dashed by the experience of an unplanned CS. The overarching theme 'the mixed emotions of becoming a mother from an emergency caesarean birth' and the related nine key themes are integrated within the

discussions of the findings. They highlight how expectations, experiences, and discourses play a central role in how the women made meaning of their caesarean birth, thus providing answers to the research questions.

The poststructuralist feminist lens adopted in the current research acknowledges how women construct their birth experiences and how these have been constructed by/through discourse. It is also concerned with how knowledge and experience shape the interactions of different acting subjects (Aston, 2016; Weedon, 1997). Therefore, the first part of this section (research questions one and two) discusses the primary findings and the analysis from the interviews with women in light of previous literature and the study's theoretical lens.

The care providers' perspectives addressed in question three are an essential source and input of women's expectations and experiences, providing an important professional and institutional context within which women experience birth and unplanned CS. Providers perspectives presented under five main themes collectively described the unique features of NZs' maternity system, the implications for the quality of maternity care experienced by women who have unplanned and emergency caesarean section, and the influence of providers' professional philosophies on women's birth constructions. Therefore, this component of the study provides the linkage between the providers' perspectives with that of the women. An in-depth qualitative approach was particularly advantageous in highlighting care providers' views. It facilitated the exploration of the midwifery and obstetric background and perceptions of care, professional status, and the nature of care delivery to women receiving emergency obstetric care within the current system. The discursive tensions between midwifery and obstetric philosophies/ideologies underpin each research question and the related findings.

Also, in this chapter, the key findings from both research groups are triangulated within the context of health service research and considering the implications for women's experiences of emergency obstetric care in New Zealand. Further, I addressed the study's strengths and limitations and highlighted recommendations for future research outlined.

7.2. The use of a poststructuralist feminist lens in the discussion of women's caesarean birth experience

In this study, I adopted a poststructuralist feminist theoretical approach to explore women's experiences of unplanned and emergency caesarean section and all that it entails. I drew upon Foucault's poststructuralist discourse analysis to understand how women exert ownership over their embodied knowledge and the nature of power relations that constitute their relationships and interactions with care providers.

Interactions with families and friends, information from media and birthing books are all key influencers that help shape an expectant mother's construct and expectation of childbirth (Martin, Bulmer, & Pettker, 2013). It gives rise to the notion that, under the same circumstances, birth expectations may differ from one woman to another, alongside the discourses and knowledge they produce. Poststructuralist theory in this regard is relevant. Postructuralim challenges the notion of fixed meaning, a unified subjectivity, and notions of power as centralised rather than distributed (Weedon, 1999). From a poststructuralist feminist standpoint, this research utilised the narratives of women's caesarean section experiences, detailing the different levels of stress and anxiety associated with having an emergency surgical birth and its emotional and psychological impacts on women's wellbeing.

Poststructuralists identify emotions as a pre-stage to meaning (Glynos et al., 2009). Meaning-making is seen as an intersubjective activity produced and reproduced through the interdependence of human and non-human elements (Durnová, 2018). Poststructuralist theory centres on knowledge, discourse, and power and how they entwine to characterise the woman's experience in childbearing (English, 2010). It recognises the dynamics of the subject as a singular entity that constantly recreates and evolves, with the power to identify as self, equipped with the knowledge to make informed decisions about one's plans and experiences (Andrist, 1997). The poststructuralist approach upholds the notion of fluidity of power, irrespective of social strata, thus, detracting from institutional power dynamics and contemporary strands of feminism characterised by hierarchical and patriarchal frameworks where gender and sexuality are inevitable. Womanhood is essentialised and determined through language, social structure, and cognition (Gannon & Davies, 2005).

However, poststructuralism is not without criticism. Poststructuralism is characterised as elitist evading the practicalities of human life, resulting in its underutilisation as an interpretive lens (English, 2010). Critics claim that the poststructuralist theory's focus on language leads to other realities being overlooked (Feely, 2016). For example, in the analysis of birth experiences, poststructuralist theories and their methodological approaches are criticised for the excessive focus on discourse and human actors, which overlook the importance of non-human elements of the birth assemblage (such as the physical hospital environment, maternity health policies) (Feely, 2019). Feminists, especially Marxist-influenced feminists, argue that poststructuralist feminism undermines the years of progress achieved in resisting patriarchal dominance and acts contrary to the strengths of unified feminism that reinforces the prowess and stability of women as a group (Gannon & Davies, 2005).

At the forefront of a paradigm shift, action network theory (ANT) and assemblage theory have prompted post-structuralist researchers to become more concerned with the non-human actants and how these are integral parts of social experiences (Feely, 2020; Locock, Nettleton, Kirkpatrick, Ryan, & Ziebland, 2016). These approaches bring to the fore the study of how an assemblage (human and non-human) elements are constituted. They also examine the negotiations between these elements before the point of association and how they act and work together to produce effects (Fenwick & Edwards, 2010). Fox discussed 'assemblages' as a constitute of networks (biological, social, psychological, and material elements) that affect and are affected by the body in a non-static but fluid manner (Fox, 2011). Poststructuralists consider that theorising the human and non-human elements of birth assemblages through discourse provides the ontological space for studying the complex relationships that produce women's everyday experiences. Narratives are conceptualised as assemblages and organising systems through which meaning-making is achieved (Frewin, 2002).

ANT and assemblage theory and their methods are considered heterogeneous and dynamic in their application providing an ontological and theoretical grounding to study a different range of social issues (Feely, 2019). Thus, neither assemblage theory nor ANT can be exclusively confined within a particular research methodology. As a fundamental, assemblage theory and poststructuralism share the constructionist view and reject essentialist assumptions. Assemblage theory was, therefore, relevant in analysing and interpreting the data, drawing from the emphasis on the experience of care as an ongoing process that is subjective and continuously constituted (Augustine, 2014). It was crucial to understanding how the non-human actors shaped the participants' experiences.

Through a thematic-discourse analysis (Jäger & Maier, 2009; Willig, 2008; Singer & Hunter, 1999), this study facilitated the analysis of women's birth discourses and the feelings/emotions that inform the meanings women make from their experiences of an unplanned caesarean section. Despite the focus on discourse, this analytical approach attends to the material or non-human assemblages often criticised for being overlooked (Feely, 2020). By seeking to understand the human element, we can make meaning of all elements of the woman's birth assemblage; what, why, and how these elements come together to shape her experience. From an ontological standpoint, discourses encompass meaning production meaning, they also constitute the entities they assume to describe (Feely, 2020). Discourses affect material bodies, and in reverse, material bodies are affected by the discourses that shape them (Gilles Deleuze, 2003). This mutuality in the material and semiotic relationship weakens the discourse/matter binary argument, which critics of poststructuralist theories have alluded.

Conducting a qualitative inquiry of women's subjective experiences of a medicalised birth does not exclude the impact of the hospital environment, procedure, and policies that guide their care management. Instead, it recognises how these assemblages have resulted in shaping and reconstructing the experiences of women. Poole and Lyne's work on women's experiences in formal healthcare shows us that passive aspects of the environment can inform how the subject takes cues and makes meaning of her experience (Poole & Lyne, 2000). The interconnectivity of human and non-human elements has inspired new theoretical frameworks and methodologies within qualitative research to re-engage with materiality. This includes a feminist poststructuralist perspective (Feely, 2020; Lupton, 2019).

Poststructuralist feminist theory studies how power and knowledge shift, including how knowledge constructions produce new identities and subjectivities (Agarwal, 2018; English,

2010; Weedon, 1997). Women's lived experiences of their caesarean birth appeared to evoke new maternal knowledge and subjectivities, such as opening discursive spaces for questioning normalised authorities, knowledge and discourses, and reclaiming displaced maternal knowledge productions in the construction of care (Agarwal, 2018). As part of meaning-making, women draw on multiple sources in their views and narratives. Therefore, their language use and discourses do not appear to be centred on particular conceptions of knowledge. Within this understanding of the existence of multiple and flawed processes and the construction of knowledge, Foucault's ideas about power being distributed as a collective effort, rather than asserted by one particular body, are situated.

The interviews captured rich data from both care providers and women about CS experience and the stress and anxiety associated with having an emergency surgical birth. Though first-time mothers in the study felt they had nothing to compare their experience with, their expectations of the childbirth experience, based on birth stories from family and friends, portrayals in the media, and birthing classes, differed from their caesarean experience. Both first-time mothers and women who had previous births believed that having an unplanned and emergency caesarean section changed their perception of childbirth and impacted their ability to care for their child the way they had expected.

7.2.1 Data Triangulation

Ongoing critical reflection of the depth and relevance of data findings was vital for enhancing the credibility of the qualitative data analysis. Initial interviews were undertaken with care providers, and this data was taken into consideration during the interviews with the women. By shaping the interview schedule, data source triangulation (Patton, 2015) became a

necessary step in exploring the personal experiences of individual women, particularly with regard to their care providers eliciting the unique perspectives added by care recipients.

During data analysis, key themes that emerged were investigated within the complimentary data set. For example, both care providers and women's views about women's knowledge of caesarean section during the antenatal period and the notion of post-surgical follow-up were analysed individually and as a single group and checked for consistency and difference with the research questions. In other instances, themes identified within one study group were not prominent among the complementary participant group. This process of convergence of information from both care providers and the maternity users was vital for data trustworthiness and, to a large extent, broadened the understanding of the research findings(Carter, Bryant-Lukosius, Dicenso, Blythe, & Neville, 2014; Patton, 2015). Given the position, unique knowledge and expertise of care providers, these key informant interviews can provide a researcher with crucial information. However, the information they offer comes from a privileged perspective (Natow, 2020). Aligning with a feminist poststructuralist view, the convergence of the professional and the lay discourses around care and caesarean section experience obtained a broader picture and understanding of the research topic. The following is a discussion of the key themes triangulating across the two data sources.

Research Question I

‘What are women’s birth expectations, and how do these compare with their experience of an unplanned and emergency caesarean section ?’

7.3. The role of normalised discourses in the shaping of birth plans, and the limitations revealed by the experience of an unplanned caesarean section.

Interviews with the new mothers reiterated the importance of birth planning regarding women’s ability to exert control and choice over different aspects of their childbirth experience. Birth planning impact women’s hopes and aspirations as they construct and anticipate their ideal birth. By speaking with the care provider about her choices, the woman promotes a sense of control over the birth and feels empowered. The relationship between birth planning and the sense of control in maternity care is supported by evidence (Farahat, El Sayed Mohamed, Elkader, & El-Nemer, 2015). Control is also associated with birth satisfaction and emotional fulfilment, especially when women’s birth plans are followed, their expectations met, and aspirations fulfilled (Farahat et al., 2015; Hidalgo-Lopezosa, Hidalgo-Maestre, & Rodríguez-Borrego, 2017; Malacrida & Boulton, 2014; Simkin, 2007; Goodman, Mackey, & Tavakoli, 2004; Simkin, 1991).

However, birth planning also create unwitting obstacles to flexibility and the devotion of much attention to specific birth expectations (Kaufman, 2007; Malacrida & Boulton, 2014; Rowe, Kurinczuk, Locock, & Fitzpatrick, 2012; White-Corey, 2013). In the current study, there was little consistency between women’s birth plans and their birth outcomes, raising questions about the role of birth plans when there is a vast difference between the ‘plan’ or

expectation and the ‘outcome’. The incongruence contributes to a sense of disappointment and lowers birth satisfaction.

In countries where midwifery dominates, such as in New Zealand, women are often (in antenatal classes) encouraged to embrace midwifery care and aspire for a medical- and technological-free birth (Davis & Walker, 2010; Jaye, Mason, & Miller, 2013). Natural birth advocates claim that women experience the most authentic form of childbirth when cared for by midwives, who emphasise partnership and woman-centred care (Freeman et al., 2004; Guilliland & Pairman, 2010). Intentional presence, and midwives’ unique embodied knowledge of childbirth, create an atmosphere of calm for women during delivery, making midwife-led birth more family-oriented (Thelin, Lundgren, & Hermansson, 2014). Some researchers believe that midwifery care promotes empathetic and more relational maternity care (Dahlberg et al., 2016; Fenwick et al., 2009; Grigg, Tracy, Schmied, et al., 2015). However, this belief is often reduced to the conception that since midwifery and midwives are female-dominated, midwives’ intuitive and reflective knowledge make them more likely to trust women’s embodied knowledge and support their capacity to give birth naturally (Beckett, 2005; Berg, 2005; Thelin et al., 2014).

Women have often relied on their midwives and antenatal educators/education for crucial information that informed their choices and birth plans (Cook & Loomis, 2012; Whitford & Hillan, 1998). Since 1990, In New Zealand, childbirth discourses have become aligned with midwifery philosophies, and antenatal education often focuses on natural birth (Grigg, Tracy, Schmied, et al., 2015). Yet, the reality remains that a ‘one size fits all’ antenatal education does not meet all women’s needs. The mothers in this study described their birth expectations and experiences as ‘polar opposites’, and stated that they were inadequately informed about CS. While most mothers had expected to have more control over their childbirth, the majority

described their participation in the childbirth process as passive. These experiences, including the loss of agency, resulted in adverse psychological outcomes for most mothers, including postnatal stress and anxiety. The experience of an emergency CS contributed to a sense of failure, loss, and disappointment regarding childbirth. Records show that a quarter of childbearing women in New Zealand deliver by caesarean section (Masukume et al., 2019; Ministry of Health, 2017). Thus, their birth experience is often outside the 'natural birth ideal' as it entails biomedical and technological interventions (Frost, Pope, Liebling, & Murphy, 2006). They are then constructed as liminal and embedded within discourses of inadequacy and failure; this exposes the sociocultural link of dominant childbirth expectations (Bayes, Fenwick, & Hauck, 2012; Fenwick et al., 2009; Grigg, Tracy, Schmied, et al., 2015; Rowe et al., 2012; Walker, 2000).

In Aotearoa, NZ, due to the midwifery dominance, women's birth plans and childbirth expectations are embedded within a 'natural birth' orientation. Yet, many women end up with an operative delivery such as CS (Masukume et al., 2019; Ministry of Health, 2017). Thus, the expectation of natural birth outcomes can become problematic (Frost et al., 2006). Failing to recognise the spectrum of childbirth experiences creates a gap between antenatal orientations and women's experience of a major surgical birth, which was evident in the current study.

The findings showed that women often looked to their midwives to affirm their birth choices and decision-making. The reliance of women on their midwives, even when the goal is to assert agency over their reproductive experience, shows the influence that midwives and other professionals involved in women's care can shape women's birth choices and expected outcomes (Westergren et al., 2019). Though the nature of the relationship between women and midwives is established on partnership and reciprocity (Freeman et al., 2004; Guilliland

& Pairman, 2010), midwives bring into this relationship a recognised level of expertise and knowledge (Dixon et al., 2017; Guilliland & Pairman, 2010; Rowland et al., 2012). Since knowledge and power are interrelated (Foucault, 1980), the midwife sits in a position of power in relation to her client as the care provider. Based on this power dynamic, it is common for women to accept midwives' opinions as expert advice in the context of their health care decision-making.

The notion of power in the patient-provider relationship is often discussed with a repressive undertone. However, Foucault's analysis of the concept of normalised power provides a socio-political insight into the construction of relationships between care providers and women within contemporary health care practices (Cheek & Rudge, 1993; Foucault & Gordon, 1980; Foucault, 1977; Paternek, 1987). Power operates subtly within encounters where a power imbalance is least expected, for example, in the midwife-woman relationship. These aspects of normalised power may constantly exist but remain subtly exercised by midwives in their relationships with the women under their care. Though it can shape the space before and then after, the need for intervention spirals.

Birth planning and natural birth discourses are closely entwined with feminist ideologies, as the women's movement was historically significant to the broader response to biomedical domination of birth (Simkin, 1980; White-Corey, 2013; Whitford & Hillan, 1998). Feminists agree with the notion that birth plans support choice for women, as, through communication and dialogue between the expectant mother and her care provider, information about options available to the woman about their childbirth is explored. Thus, women are supported to have more control over their childbirth (Cook & Loomis, 2012; Kitzinger, 1988; Moore & Hopper, 1995). However, the claim that birth plans enhance choice has also been criticised as overstated, mainly where the dialogue and communication discourse is inflexible and

narrowly conceptualised within specific birth ideologies (Too, 1996; Whitford & Hillan, 1998). Additionally, there is an assumed sense of responsibility placed on the woman to articulate and comply with the identified goals of her birth plan (Hidalgo-Lopezosa et al., 2017; Malacrida & Boulton, 2014). For example, making choices that ensure her childbirth is intervention-free. Consequently, when delivery does not go according to plan, women can sometimes share the blame if, in retrospect, their choices were outside professional recommendations (Goer, 2010; Schneider, 2018). Or, a traumatic labour and birth experience can be linked to the woman's fear of childbirth (Harris & Ayers, 2012; Karlström, 2017; Waldenström, Hildingsson, & Ryding, 2006). As such, birth planning can become a tool for disciplining women by controlling conformity to certain health behaviours (Malacrida & Boulton, 2014).

The findings in this study showed a focus on natural birth in the women's interactions with their midwives. This finding supports evidence highlighting midwives' roles in promoting natural birth among childbearing women (Aune, Holsether, & Kristensen, 2018; Dahlberg et al., 2016). Most mothers felt they received little information about caesarean section in their interactions with midwives and antenatal educators. Participants described feeling unprepared for a caesarean section and all that it entailed. Having little knowledge about CS and feeling 'thrust' into a highly medicalised birth resulted in distress for many mothers and amplified the tension between their expected delivery and the reality of CS. The way hospital birth was discussed during antenatal classes – in terms of exposure to risk and cascading interventions – contributed to the fear of hospital birth among women. These discourses imply that the hospital is viewed as a trigger for intervention. Thus, women described experiencing higher levels of anxiety on arrival at the hospital. Literature also indicates labour progress slows on arrival at the hospital (Brocklehurst et al., 2016; De Jonge et al., 2017). These points suggest

that these discourses may be significant contributors to preoperative anxiety among women who experience an unplanned caesarean section.

According to Porter and colleagues, limited information about other possible realities outside expected birth outcomes can increase fear and panic among women who experience an unplanned CS (Porter et al., 2007). Poor information/communication about caesarean section in the antenatal period was also identified by Afaya et al. to negatively impact women's experience of an emergency CS (Afaya et al., 2020). Similarly, Burcher et al. noted that in prenatal birth discussions, providers' lack of transparency and poor communication could result in distrust of care providers and patient's dissatisfaction and regret (Burcher et al., 2016). They suggest that women may cope better when a birth outcome is within the realms of possibilities, as significant and unexpected changes can increase anxiety about unforeseen outcomes.

Women believed that adequate information from health professionals about possible alternative outcomes could have lessened the shock and anxiety they experienced. In their view, knowledge about caesarean section in the antenatal period would empower them to prepare for other outcomes. In addition, most participants questioned the sole focus on natural birth discourses in antenatal classes, which did not reflect their reality. Challenging dominant narratives, women appeared to set aside the conflicting meanings (shaped by language) of antenatal childbirth discourses. There is the meaning within contemporary discourses that often impose their orthodoxies on women and influence how they understand and make meaning of their lived experiences (Walsh, 2007; Hirschmann, 2018). However, caught between the pervasiveness of natural birth discourse and the experience of highly medicalised birth, women were compelled to resist this discursively and constructed their meanings/discourse from their experiences. While this 'resistance' has often focused on how

women negotiate their agency within hegemonic discourses of medicine (Walsh, 2007), a new dimension of this is observed within this study. In particular, women challenged the hegemony of the natural birth discourse and the resistance of the medical model in the childbirth classes, which in the context of their caesarean birth, was incongruent with the reality of their experience.

Foucault's theory of governmentality and bio-power is informative in this context and in the understanding of the control of health behaviours. In his series of public lectures in the late 1970s, Foucault advanced his analysis and refinement of political power and the technologies of power that govern individuals and social relations (Bevir, 2010; Bröckling, 2010; Foucault, 1991; Lemke, 2002; Lupton, 2013). His concept of governmentality offered an illustration of the idea of control behaviours and how power constitutes normalised forms of knowledge (Bröckling, 2010; Lemke, 2001). The study of power techniques and forms of knowledge underpins most of Foucault's work. Despite constituting some of his criticism, Foucault focused on how power in its neutral sense can be both productive and at the same time, repressive (Foucault, 1982). In Foucault's view, individual choices and actions regarding health and risk are constructed and confined within socio-political, scientific, and medical discourses and relationships (Foucault, 1991; Malacrida & Boulton, 2014). From the perspective of modern governmentality, and within Western civilisation, improving health frequently requires the control and change of health behaviours (Foucault, 1991). The operations of bio-power are, therefore, applied through the institutions of government - which Foucault conceptualised in a more general context outside the political inclination (Lemke, 2001) - to mould and regulate individuals' behaviours to meet specific health goals (Alianmoghaddam, Phibbs, & Benn, 2017). The development of policies around antenatal

birth literacy can become an enactment of bio-power by the disciplining expectations of both natural and medicalised birth discourses (Malacrida & Boulton, 2014).

Birth discourses have historically been embedded within paradigms of natural and interventionist birth, highlighting the need to move outside the limits of polarised birth ideologies, where the discourses of childbirth and the places in which it occurs can be situated within a multiplicity of birth models (Frost et al., 2006). This shift in how childbirth is constructed, discussed, and delivered, recognises different perspectives and allows for their legitimacy beyond the boundaries of professional boundary keeping (Frost et al., 2006). As Foucault recognised, no discourse is immune to intolerance of difference, and discourses are the vehicle through which power operates (Foucault, 1973). In his view, every relationship consists of two sides, one with the knowledge that exerts power over the other, positioned with lesser knowledge (Foucault, 1991). In the care providers-women relationship, health professionals control the body of knowledge. However, the concept of governmentality is moving on from the simplistic assumption that one party dominates the other to argue that power becomes diffused throughout society. In essence, while professional bodies may have had an important role in determining the dominant discourse (normal birth) the power of upholding those discourses becomes a responsibility for all in society, for example, the antenatal educators and mothers groups. This is important for professional groups as most have moved on from assumptions of professional power and perhaps explains why concepts of natural birth have become so pervasive.

Care providers and antenatal educators can support women by ensuring that the birth models they practice are women-centred rather than profession-driven. This can begin with how women are supported to prepare for childbirth and the information that is given about ‘non-natural’ birth outcomes (Reenen & Rensburg, 2015). Exposing women to the intricate

nuances of different birth experiences and outcomes (Davis-Floyd, 2001; Frost et al., 2006), based on informed choice and decision-making rather than a single, idealised conception of birth, can enhance their preparedness for a birth outcome outside a normalised ideal.

Research Question II

How do women's experience of unplanned/emergency caesarean section impact their physical and emotional well-being and their transitioning to motherhood?

7.4. Wellbeing in the transition to motherhood

The research findings showed a wide range of challenges and shared experiences among women and the impact of these experiences on the perception of motherhood after an unplanned caesarean section. Adjusting to the maternal role was difficulty for mothers, who linked the challenges experienced in the early postnatal period to the distressing nature of their childbirth experience. Many of the participants' experiences showed that the reality of motherhood after an unplanned CS fell short of their aspirations and expectations of motherhood. The depiction of diminished mothering and caregiving capability was linked to pain complications, limited mobility, and emotional exhaustion from the caesarean birth. These were against certain expectations women had about caring for their newborns after delivery.

The analysis provides interesting data about birth difficulty and links with the immediate connection between women and newborns. Delayed initial contact with infants due to clinical assessment resulted in the maternal-infant separation and evoked emotive reactions among women. The implication for maternal anxiety and adverse emotional reactions from mothers towards their newborns is evident and reported in previous studies (Crenshaw, 2014; Dumas et al., 2013). Though immediate contact between a mother and her infant is crucial for maternal sensitivity and emotional fulfilment (Bystrova et al., 2009), the tradition of mother-

infant separation remains common after CS, especially when unplanned (Ayala et al., 2016; Forti-Buratti et al., 2017b; Gathwala & Narayanan, 1991a; Stevens et al., 2014).

Some women can sometimes view the experience of uncomplicated pregnancy as evidence of an existing special connection between them and their unborn child (Lothian, 1999; Lothian, 2008b; Salehi & Kohan, 2017). Thus, there is an expectation of the circumstances around labour and childbirth to facilitate the progression of this connection (Beckett & Taylor, 2019; Eswi & Khalil, 2012). Women's narratives suggested that a natural (vaginal) birth was integral to the progress of the prenatal bond with their foetus and their transitioning to motherhood. This is important in light of the notion that maternal-infant attachment is mainly established in the early periods after birth (Bowlby, 1969). However, recent studies have claimed that this may begin from the start of pregnancy long before birth (DiPietro, 2010; Honemeyer & Kurjak, 2014; Kuo et al., 2013; Sedgmen, McMahon, Cairns, Benzie, & Woodfield, 2006). Women's awareness, sensitivity, and behaviour towards the foetus can influence emotional connection and facilitate stronger attachment after birth (DiPietro, 2010; Güney & Uçar, 2019; Kuo et al., 2013). In this study, the participants valued their connection with their infants during pregnancy and expected that a favourable and expected birth outcome will cement this connection. The experience of an unplanned CS was predominantly viewed to have initially disrupted the continuity of the connection and attachment women felt with their unborn child during pregnancy. Consequently, women felt emotionally complicated about their early motherhood experience.

Evidence shows that delivery mode impacts women's subjective experiences of positive emotions with their newborns in the early postnatal period (Guittier et al., 2014; Kjerulff & Brubaker, 2018; Reisz et al., 2015; Rowe-Murray & Fisher, 2001; Spaich et al., 2013). Natural (vaginal) birth is popularly believed to strengthen these emotions and the mother-

infant connection and promote easy transitioning to motherhood (Parratt, 2002). Disruptions in women's expectations of labour and childbirth can be traumatic and may result in maternal adjustment difficulties (Benton et al., 2019; Husby, van Duinen, & Aune, 2019; Priddis et al., 2018; Reenen & Rensburg, 2015). In the current study, the disruptions preventing mothers from cuddling their newborns and initiating breastfeeding immediately after the CS made most women blame the mode of delivery for the difficulty in forming close bonds with their infants in the postnatal period. Women believed that the associated post-caesarean complications affected their physical capabilities to perform their maternal roles and responsibilities. Similar to studies elsewhere (Van Reenen & Van Rensburg, 2013), the findings further show that pain, sleep disorder and emotional disturbance further complicate adjustment to motherhood after an unplanned CS.

Women often construct certain assumptions and expectations regarding postpartum experiences with their infants. These are generally optimistic, as they strive for normality about how they feel and the way they expect to care for their newborns soon after childbirth (Harwood, 2004; Way, 2012). The expectations can be generated or produced via normative knowledge that is part of normalised discourses related to mothering expectations. Neoliberal framing of motherhood within mothering discourse contributes to the intensification of motherhood, whereby mothers are expected to fulfil specific responsibilities. For example, in infant care and breastfeeding, often discursively shaping mothering to fit with constructed roles of women (Auðardóttir & Rúdólfsdóttir, 2020; Gíslason & Símonardóttir, 2018; Símonardóttir, 2016). Feminist studies, however, have highlighted the problematic understandings of ideological preconceptions in birth discourses that shape women's lives (Miller, 2007). These neoliberal views of postpartum romantic preconceptions are forms of governmentality that often seek to shape optimism and positivity even in adversities (Gill,

2017; Varadi, Raby, & Tardif-Williams, 2020; Wall, 2001). However, they can contribute to maternal stress and anxiety and the negative perceptions of postpartum experiences that diverge from pre-birth expectations (Auðardóttir & Rúdólfsdóttir, 2020). Consequently, feminist scholars and poststructuralists have called for closer scrutiny of feminist and maternal scholarships and raised awareness for the need to listen to what women are saying about their birth and postpartum expectations to address these assumptions and mothering expectations (Wall, 2001)

7.5. Psychological and emotional reactions from an unplanned caesarean section

The findings highlighted women's emotional vulnerabilities from an unplanned CS. The participants described experiences of self-disconnection and emotional detachment from their infants. They described their dissociation as trauma-related which resulted in negative perceptions of postnatal experiences.

The participant's description of their CS was compared to a near-death experience similarly reported previously (Flint, 1986). The long and distressing labour, the uncertainty of an emergency CS for women, elicited emotions of fear and anxiety and confusion in some situations. Fear of harm or death to their child or themselves before and during the caesarean section appeared to engulf women's memories of their birth. Revisiting these emotions caused some levels of distress for some women who were emotive and upset recounting their stories.

Research has shown that the memories of a traumatic experience of near-death can trigger post-traumatic stress reactions after delivery (Wijma, Söderquist, & Wijma, 1997). This

reality is reportedly common for most women after unplanned CS experiences (Rowe-Murray & Fisher, 2001; Ryding, Wijma, & Wijma, 1998).

The experience of psychological distress has been shown in qualitative research to cause significant postpartum challenges (Clement, 2001; Fenwick, Gamble, & Mawson, 2003). Similar to these findings, the participants in the present study complained about the difficulties they experienced caring for and nurture their newborns. For most women, this experience contributed to detachment feelings that women felt confused about, as they had expected more connection between them and their infants. Such experiences of disconnection and poor relationship satisfaction with the infant can result in feelings of loss and nonfulfillment of desire and mothering goal, which may lead to the experience of postpartum depression (Quintero, 2014). Therefore, it highlights the importance of clinical support for women following unplanned operative delivery even when they do not present clinical symptoms.

Despite the adverse psychological outcomes reported by the participants in the findings, only a few women said they were medically diagnosed with postpartum depression or post-traumatic stress disorder PTSD or received professional support. Most of the mothers felt that available mental health support was limited. They mainly relied on their partners, mothers, and social media post-birth trauma support groups to help them cope with the emotional and psychological stress and anxiety experienced. Community midwives were often the external support within the maternity system that women found helpful too. Though, most women felt that midwives were often more focused on the wellbeing of their infants during this four to six week period. Thus, it suggests that women’s psychological needs after an unplanned CS may not be fully met within the current postnatal care system.

The current rate of postnatal depression in New Zealand is estimated at 14% (Gao, Paterson, Abbott, Carter, & Iusitini, 2010; Health Promotion Agency, 2016; Waldie et al., 2015), compared to the global average of 13% (WHO, 2020). Similar to the findings in this study, previous reports have noted that women experience difficulty finding the right places to seek support (HPA, 2016). Interestingly, in the current study, women were more forthcoming with seeking online social help as an alternative due to the perceived difficulties in access to proper clinical care for the postnatal psychological reactions.

The findings of psychological distress among most of the participants following their unplanned CS supports reports in previous research (Ayers, Bond, Bertullies, & Wijma, 2016; Clement, 2001; Fenwick et al., 2015; Koster et al., 2020; Rowlands & Redshaw, 2012; Ryding, Wijma, & Wijma, 1997; Ryding, Wiren, Johansson, Ceder, & Dahlstrom, 2004; Wijma, Ryding, & Wijma, 2002). Similar to reports elsewhere (Lobel & DeLuca, 2007; Reenen & Rensburg, 2015; Størksen, Garthus-Niegel, Vangen, & Eberhard-Gran, 2013), lack of information about CS during birth preparation was a notable theme in the present study. As most women reported a lack of prenatal education about CS, adapting CS information to maternal health literacy to adequately prepare expectant mothers could potentially help women cope better and limit the chances of PPTSD after an unplanned CS.

Women's ability to exert control in childbirth is essential in their childbirth experience and postnatal wellbeing (Caroline et al., 2014). Therefore, the nature and level of involvement of the woman in the decision-making process and the attitude of care professionals supporting the woman during emergency CS can impact the promotion of maternal wellbeing postnatally (Noseworthy, Phibbs, & Benn, 2013). Finally, the psychological outcomes from an unplanned CS have vast implications for women's wellbeing and future pregnancy

(MacMillan, 2011). Increased community obstetric mental health support may minimise adverse psychological outcomes for women following traumatic unplanned CS.

7.6. Breastfeeding difficulties, negative self-assessment, and women's quest for validation

Consistent with recent reports, the research findings show that unplanned CS can contribute to negative breastfeeding experiences and infant care (Hobbs et al., 2016; Meric, Ergun, Pola, Yayci, & Dal Yilmaz, 2019). Participants' accounts of breastfeeding experiences revealed that despite their intention to breastfeed, most women experienced breastfeeding difficulties, consistent with reports in the literature (Hobbs et al., 2016; Karlström, Engström-Olofsson, et al., 2007; Meric et al., 2019; Tully & Ball, 2014). Karlström et al. (2007) had noted that following caesarean birth. Most women experience challenges with breastfeeding due to obstacles associated with operative deliveries, though insight into these obstacles was unexplored. However, Tully and Ball (2014) identified barriers such as incisional pain complications resulting in positioning difficulties, limited maternal mobility, maternal fatigue, and the infant's lack of interest. The current research shows that while there was diversity in women's breastfeeding experiences, everyday challenges included inadequate milk production beyond days three or four, trouble with latching, and infant's inability to suck, maternal incisional pain complications, pain from sore nipples, and maternal emotional challenges. Most women linked the difficulties experienced with breastfeeding to their mode of delivery despite reports showing that most mothers, irrespective of the mode of delivery, experience both short- and long-term breastfeeding difficulties (Gianni et al., 2019). Yet, most new mothers have high expectations for breastfeeding, which can result in disappointment and a sense of disempowerment when not met. This may suggest issues of

unrealistic expectations and lack of preparedness about possible breastfeeding difficulties in the antenatal period. While breastfeeding may continue to be viewed as the normative source of nutrition for infants, giving women a better understanding of what happens to their bodies during/after birth rather than (again) 'the one size fits all' antenatal education, can help women view potential challenges as a common phenomenon rather than a result of their individual shortcomings (Williamson, Leeming, Lyttle, & Johnson, 2012).

Women's eagerness to breastfeed after a CS can also be linked to the need for mothers to meet other maternal subjective identified needs outside infant nutrition. Most of the mothers believed that breastfeeding set the emotional tone for their relationship with their newborns and offered them a chance to retake control and challenge the medicalisation of their maternal bodies and embodiment (Wall, 2001). Beck and Watson (2008) proposed that women who give birth by an unplanned caesarean section can often strive to make up for their inability to birth naturally, thus, are eager to meet the needs of their newborns, as a way to vindicate themselves from the sense of failure. In this context, the findings showed that most mothers sought the psychological benefit of attaining a sense of emotional fulfilment and satisfaction through breastfeeding to make up for the failed natural birth. Thus, the purpose of the obligation that women attached to breastfeeding appeared to be more as a means to attain an idealised maternal identity. While breastfeeding is mainly to meet the infant nutrition needs (Tully & Ball, 2014), breastfeeding is also known to have other maternal and infant health benefits (Binns, Lee, & Low, 2016). For example, breastfeeding supports optimal infant health (Oddy, 2017), it fosters maternal-infant sensitivity and attachment (Choo & Ryan, 2016; Kim et al., 2012), and plays an important role in women's recovery after childbirth; by helping to reduce postpartum bleeding, and stimulating oxytocin release which facilitates the contraction of the uterus (Stuebe & Schwarz, 2010).

The birth of a child also brings a new identity (of motherhood) with it. Therefore, becoming a mother can be interpreted as an identity shift, which existentially changes the woman's physical, mental and emotional sense of self, her values, and her interpretations of the world around her. The developmental transition to motherhood - a matrescence (see chapter 6.8) (Mercer, 2004; Sacks & Birndorf, 2019; Thomas, 2001) - can bring about a conflict of identities. In maternity discourses, this is largely unexplored. In ascribing meaning to the transition to motherhood, much focus is on the act or process of 'giving birth' (Prinds, Hvidt, Mogensen, & Buus, 2014). Several participants described a range of postnatal experiences of frustrations, confusion, fear, detachment, anger, and failure as they attempt to know themselves and their new roles better, as well as the eagerness to meet the demands of their new identity. Further challenges experienced in trying breastfeeding, for example, become 'extra baggage' that affects the new maternal identity's attainment and/or performance.

While breastfeeding is viewed as a natural process, it is also a learned experience that often requires education (National Breastfeeding Advisory Committee, 2008). It was evident that most of the mothers in this study needed some form of help and support around acquiring knowledge and skills about breastfeeding. Predominantly, the mothers felt they were not adequately supported and did not have access to breastfeeding consultants while in the hospital. Where support from lactation consultants was available, the mothers described this as significant in helping them build self-confidence about breastfeeding and cope better with breastfeeding challenges.

Feminist literature promotes breastfeeding support. However, some feminist scholars have questioned the 'sex-specific' attributes of breastfeeding normalisation, which conflicts with the feminist discourse of gender-neutralism (McCarter-Spaulding, 2008). When breastfeeding is constructed as the mother's responsibility to her child, her "special gift" to her newborn,

her perceived sense of 'good mothering' is often connected to her ability to breastfeed her infant (Wall, 2001, pg 605). Therefore, a mother can be viewed as irrational, selfish, and lacking 'good mother' traits if she withholds breastfeeding from her infant, as the infant and herself may be susceptible to health risks (Stuebe, 2009; Wall, 2001). Embedded in such narratives is a sense of obligation on mothers to breastfeed. This obligation, according to draws its authority from wider socio-culturally constructed discourses of nature, motherhood, and good mothering (Wall, 2001). In this light, pro-breastfeeding health discourses, when framed in a manner that restricts permissible reasons for mothers not breastfeeding, can induce maternal guilt and contribute to maternal psychological harm and trauma, particularly after a traumatic birth experience (Taylor & Wallace, 2012).

With the growing breastfeeding health discourse, there has been a global push for breastfeeding as a 'moral' recommendation for every mother in infant feeding (Binns et al., 2016; Blincoe, 2005; WHO, 2002). Yet, there are considerable differences in knowledge, skill, and the impact of varying circumstances, such as mode of delivery, social and medical factors, that affect women's ability and capacity to breastfeed (Lööf-Johanson, Foldevi, & Rudebeck, 2013). Breastfeeding has been described as an empowering experience for many women which draws attention to women's rights and gender equality, thus, addresses critical feminist issues (Van Esterik, 1994). Yet, mothers who do not breastfeed either due to circumstances or based on choice often feel the need to defend their decisions, as they may feel judged and appraised negatively (Leurer & Misskey, 2015). This experience, coupled with the sense of disappointment women already felt about their inability to birth naturally, can increase their vulnerability to posttraumatic stress, anxiety, and depressive symptoms. Providing individualised support that considers the women's subjective experience of an

emergency caesarean birth is crucial to fostering psychological growth while tackling breastfeeding challenges.

Research Question III

What are midwife and obstetrician LMC's perceptions of intrapartum and postpartum care and support for women who have unplanned and emergency CS within the NZ maternity system?

7.7. Lead maternity care model: contesting childbirth as a primary and secondary event

The analysis from the care providers' interviews demonstrates that midwives and obstetricians are equally committed to continuity of care. They agree that NZ's midwifery-led maternity system supports a culture of responsiveness and a women-centred model of maternity care. Indeed, robust evidence supports the benefits of midwifery-led continuity of care (Sandall, Soltani, Gates, Shennan, & Devane, 2016). However, care providers recognised that an unplanned caesarean section irrevocably changes the birth experience and the care provider's views. The broader literature further recognises that an unplanned caesarean section compromises women's expectations and satisfaction with their birth (Boyce & Todd, 1992; Sadat et al., 2014). This dissatisfaction contributes to feelings of low self-esteem, a sense of failure and guilt, post-traumatic anxiety and depression, which may have a long-term impact on women's bonding with their newborn, and their overall wellbeing (Karlström, 2017; Reenen & Rensburg, 2015; Sadat et al., 2014; Wijma et al., 2002).

Though midwives see themselves as co-partners with women, particularly in their efforts to support them to achieve normal (vaginal) delivery, they, however, acknowledged their positions as 'expert voices' for their clients. Obstetricians more openly adopted an 'expert' role, recognising that they are not passive in making decisions for, sometimes with, women.

In their view, clients will always look to them in difficult circumstances to make the ‘right’ decisions due to their medical expertise and knowledge. They considered themselves well prepared for this. Thus, their recommendations of appropriate clinical interventions and their management of relationships with pregnant women are made in quick time. On the other hand, midwives acknowledged their ideological position as ‘guardians of normal birth’ and ‘champions’ of women’s birth rights and autonomy in the ways they maintain their partnership with clients and diminish power discrepancies (Thomson, 2004).

Midwives dominate NZ unique maternity care system. Obstetricians in this study acknowledged this view but shared concerns about the dangers of a ‘normal birth’ ideology with “religious zealotry”. Obstetricians’ descriptions of birth as ‘unpredictable’ countered midwives’ framing of birth as normal/natural and justified the urgency and need for caesarean section. As previous research has identified, though biomedical discourses of childbirth and obstetric care remain dominant within the hospital setting, midwives have consistently re-positioned women at the centre of maternity care by disrupting mechanised constructions of the maternal body and childbirth (Davis & Walker, 2010). In so doing, midwives not only make an effort to create the space for women under their care to re-discover their agency and capacity in childbirth, but they also continue to re-position their practice, philosophy, professional identity, and autonomy within alternative care models (Bradfield, Hauck, Duggan, & Kelly, 2019; Scamell, 2014).

Despite midwives’ dominance in maternity care, women still see doctors as the more knowledgeable professionals, and their knowledge is considered authoritative and persuasive (Browner & Press, 1996; Jordan, 1997). This makes women hardly question doctors opinions; instead, they willingly surrender to their authority.

The transformation of maternity care in most developed countries has seen the professionalisation of midwifery and the return of autonomy to midwives (Andrea Gilkison et al., 2016). Also, community-based midwifery practice has seen medical hegemony challenged and the midwifery dominance in maternity care become popular (Andrea Gilkison et al., 2016; Hunter & Segrott, 2014; Jaye et al., 2013; Stojanovic, 2008, 2010; Worman-Ross & Mix, 2013). Yet, the view that childbirth is risky and unpredictable see doctors take the lead position when labour and delivery become difficult (Chadwick & Foster, 2014; Healy et al., 2016a; Luce et al., 2016).

Foucault's theory of modern-disciplinary society illuminates how the concept of disciplinary power and knowledge serve as a tool for control and social normalisation of power. Wherein specific ideas, knowledge, and behaviours outside of the social norm are constructed as ideal (Foucault, 1980). In Foucault's account, normalised societal power makes us see certain expectations as the norm and creates our views of what we believe is valid or objective based on those expectations. Consequently, our beliefs and world view, and to a large extent, our decisions are shaped to conform to these unforced yet, power-wielding normalised expectations (Foucault & Gordon, 1980; Heyes, 2007; Lawlor & Nale, 2015; Varea & Underwood, 2016).

The term disciplinary medical power describes how medical practice wields power in a manner that patients feel coerced to conform to decisions and recommendations of medical professionals (Fahy, 2002). In such circumstances, the distribution of power sees women and midwives self-regulate their behaviours and decisions in compliance with the power structures of the dominant medical profession, as such, negating women's individual and midwives' professional autonomy (Brailey et al., 2017).

The connection between power and knowledge comes to life when power is conferred to those with knowledge. At the same time, since knowledge confers power, those who wield power are accepted to hold 'absolute' truth and knowledge and can control what is accepted as idealised norms (Brailey et al., 2017; Fahy, 2008). Evidence-based medicine is typical here and represents how dominant knowledge is used to wield power in maternity care settings. As women are confronted with the current best evidence, if conveyed to them in a directive manner, they become subjects to the imposition of medical protocols in clinical decision-making (Fahy, 2008). Where women feel dominated by physicians authority, it can 'tyrannise' the experience of maternity care for women and subvert their embodied knowledge (Benoit, Zadoroznyj, Hallgrimsdottir, Treloar, & Taylor, 2010; Brailey et al., 2017; Fahy, 2008; Ortiz, 1993; Worman-Ross & Mix, 2013). The institutions that house and spread scientific knowledge are intrinsically sources of normalised power across societies (Foucault & Gordon, 1980). It may be impossible to remove ourselves from the influence of society's normalised power. However, by understanding how we are subjects to the different dynamics of power (through knowledge building), we can determine how much we are influenced by power.

In the narratives of participants, it was evident that within the maternity system, obstetricians and midwives locate themselves in a constant web of power transactions as they navigate the historical dynamics of the maternity care system in New Zealand. The findings demonstrate how as the dominant maternity provider in New Zealand, midwives' perspectives have emerged as the moral standard upon which idealised notions of a natural birth are established for many women. Conflicting discourses suggest midwives are caught between the competing demands of their clients and the disciplinary power of medical hegemony in their attempt to maintain companionship with their clients through labour complications and the increasing

technology of the hospital environment (Brailey et al., 2017; Worman-Ross & Mix, 2013). Obstetricians, however, viewed themselves as realists whose influence on women is based on medical realities and a culture of safety. These diverse philosophies were seen as determining factors in how both groups of professionals articulated their thoughts, viewed their roles, and constructed their language in their interactions with women. Despite these differences, midwives and obstetricians alike agreed that valuing women's rights, choice, and autonomy in their maternity journey is crucial in ensuring woman-centred maternity care.

The findings highlighted how risk perceptions by carer providers play an important role in clinical decision-making in maternity care and, in the ways, the different philosophical assumptions around childbirth are conceptualised. Risk management is standard within the medical practice and effective in creating a culture of fear and uncertainty in the discourses surrounding birth and has been found to affect how it is managed by maternity service providers (Bryers & Van-Teijlingen, 2010; Chadwick & Foster, 2014). Professionals' practice guidelines influence the differing value and perceptions of risk, impacting women's decision-making processes around labour and childbirth (Healy et al., 2016b). Arguably, birth has become redefined in terms of blame, harm, hazard, and safety (Scamell, 2015), creating an atmosphere of fear and risk culture that sometimes constrains woman's choices and decisions (Chadwick & Foster, 2014; Hood, Fenwick, & Butt, 2010). This fear, however, is not unfounded as studies have shown that threat of litigation and blame has seen midwives support and practice medicalised birth interventions even where they disagree with the obstetrician's view (Hood et al., 2010).

The findings also affirm the rhetoric of 'normality' and 'abnormality' around childbirth and the tendency for this to be subsumed by conceptualisations of risk (Norris, 2001; Scamell & Alaszewski, 2012). These socially constructed categories, often ambiguous and fluid, have

remained the distinction upon which professional philosophies in maternity care between midwives and doctors are characterised (Hunter & Segrott, 2014). This finding, therefore, supports evidence that maternity care providers' perceptions of risks account for some of the observable differences in the management of women's care (Page & Mander, 2014; Pearson et al., 1995). This self-preservation of organisational and professional conceptions of risk and patients' care takes precedence over the clients' interpersonal needs. Ultimately, this does not always serve the client well in their care, as the influence of professional's knowledge and power often trumps shared decision-making in women's maternity care with implications for their birth experience and satisfaction (Seibold, Licqurish, Rolls, & Hopkins, 2010; Walsh, 2010).

7.8. **Being present: testing the midwife-woman relationship when disruptions occur**

The findings from the interviews support earlier reports that transfer from birthing unit to hospital is a relatively common experience among women planning their birth in a midwifery unit (De Jonge et al., 2014; Grigg, Tracy, Schmied, et al., 2015; Rowe et al., 2012). The current study further presents evidence that women are vulnerable to a sense of disappointment with their birth experience when transferred from midwifery to hospital care, which is reflected in other qualitative studies (Creasy, 1997; Kuliukas et al., 2017; Rowe et al., 2012).

A consequence of a transfer of care is the halt in planned midwifery care (Creasy, 1997). Though temporary, this can result in feelings of sadness, as women often felt supported by their midwives and envisioned continuity in that relationship. However, transfer of care creates a 'disturbance' in the woman-midwife relationship and often results in a deviation

from the aspired ‘ideal’ birth. Women moving from a familiar (midwifery) context to an unfamiliar (medical/hospital) setting during labour and childbirth can experience increased tension and mood changes (Crowther et al., 2014; Kuliukas et al., 2017). In this study, reports of distress, confusion, and anxiety were common reactions of women following a transfer of care. Most women identified that these adverse reactions impacted their attunement to obstetric care. Unlike their planned midwifery care, most mothers were unsure of what to expect from an unfamiliar carer (obstetrician). Previous studies have reported similar concerns relating to expectations and uncertainty impacting how expectant mothers who experience a transfer of care perceive the concept of transfer (Beake et al., 2010; Creasy, 1997; Grigg, Tracy, Schmied, et al., 2015; Rowe et al., 2012; Van-Stenus et al., 2017).

For a few of the participants, the transfer of care was a positive experience. Mainly due to felt assurance of high-level care and perception of ‘promised safety’ in the context of the ongoing complications. However, this sense of ‘promised safety’ did not appear to assuage the feeling of distress from having an operative delivery for these mothers. Most of these women described feeling exhausted and traumatised and simply wanting the birth to be ‘done’. Discussion of possible transfer between women and their midwife LMCs varied among participants. Only a few felt they received adequate information from their LMC of what a transfer entails. The experience of an uncomplicated pregnancy can mean there is a reduced likelihood that such discussions have taken place. Grigg et al. found that such discussions can help women maintain a sense of control and facilitate a more positive experience of transfer of care (Grigg, Tracy, Schmied, et al., 2015). Rowe et al. (2012) also identified that women receiving early and adequate information is protective against anxiety and ‘fear of the unknown’, which can help women adjust to the changing circumstances around their care. The findings in the current study support these views. Though a minority, some women who

reported in-depth discussions with their midwives reported feeling more in control of their emotions and less anxious about the changes in their care. Therefore, care providers who effectively engage their clients with information about possible outcomes outside the expected norm can help promote a more positive experience of abrupt transfer of care. Regardless of where and how the woman has planned to give birth, openness to these outcomes can help protect against adverse reactions to care transfer. The relationship between a woman and her midwife LMC is an essential element determining how women cope with their transfer of care experience. Women who spoke of a complicated relationship with their community midwives also perceived their transfer experience negatively.

7.8.1. Midwives being with women in the caesarean room

The role of the community midwife to her client during an unplanned caesarean operation was unclear to most women who expected that their midwives would actively participate in their birth regardless of their care being transferred. About half of the participants' midwife LMCs were unavailable during the caesarean section. This is understandable owing to the long period midwives may have been caring for their client before the transfer of care and the practice guideline of LMC services to clients after a transfer of care [See the New Zealand *Primary Maternity Services Notice 2007* - Ministry of Health, (2007)]. The guidelines specify - "if responsibility for a woman's care transfers to a secondary maternity service or tertiary maternity service after established labour, the woman's LMC may continue to support the woman" - (Ministry of Health, 2007, pg. 1060). This language suggests that while, in this case, the midwife LMC continues to hold the responsibility of care coordination, she has no professional obligation to continue providing care after transfer. This view is further stressed

in the general requirement for payment claim for LMC services, which holds that "there can be no claim for lead maternity care if a woman has transferred to secondary…or tertiary maternity" (Ministry of Health, 2007, pg. 1062). Thus, the midwife may choose to stay with her client during this period but will not receive payment. Indeed, a midwife may decide to prioritise other cases in which she is paid as LMC. Given workloads, that is entirely likely. It reflects the complexities and cross-cutting influences of formal institutional policies within the maternity system and the broader impact on women's maternity care experience. From the midwifery perspective, it further demonstrates how midwifery is constantly redefined by institutional financial policies (Benoit et al., 2005)

There was a general sense of disappointment among women whose midwives were unavailable during the caesarean delivery. Women who had their LMCs in the operating room during the CS reported a more positive experience. Consistent with the literature, midwives provided emotional companionship to their clients (Lundgren & Berg, 2007). This highlights the importance of sensitive and supportive care to women during complicated childbirth. It shows the impact the presence of a familiar care provider can have on the woman's experience of an unplanned caesarean section (Rowe et al., 2012).

The concept of midwives *being with women* is relevant in the participants' expectations of presence from their midwives. 'Being with women' is symbolised by 'presence' (Aune, Amundsen, & Skaget Aas, 2014; Hunter, 2015). It underpins the midwifery practice and philosophy of continuity of care and is the sustaining element of the midwife-woman relationship (Aune et al., 2014; Bradfield et al., 2019; Lundgren & Berg, 2007; Thelin et al., 2014). In addition, 'being with women' reflects the theoretical underpinning of woman-centred care (Fahy, 1998; Hunter, 2015; Hunter, 2002), and it is fundamental to the feminist ethics of (egalitarian) care (Fontein-Kuipers, de Groot, & van Staa, 2018; Morgan, 2015).

The transfer of care and an unplanned CS is seen as a threat to the midwife's presence in the birthing room. It has both emotional and psychological implications for women and professional and philosophical ramifications for midwives. Women's conceptions of their relationship and the midwife's commitment to their care extend beyond the boundary of practice philosophy that limits midwives' engagement after the transfer of care. Women expected their midwives to be with them throughout their experience, especially during the CS. This expectation is related to a "continuing personal relationship" (Creasy, 1997, pg. 38), which women believe holds midwives to a commitment of presence. When midwives focus solely on the clinical outcomes for women after the transfer of care, there is the tendency to downplay the experiential and subjective elements of women's constructed meanings of the midwife's presence during childbirth. The danger is that contrary to feminist philosophies, this focus may valorise women mainly as means of production (Fontein-Kuipers et al., 2018), and childbearing, within the medical space, as a form of 'alienated labour', instead of an emotional experience for the mother (Russell, 1994). In these circumstances, women's subjective experiences and meaning-making of childbirth are less valued.

7.9. Debriefing and expectations of continuity of carer

The findings reveal that when women's expectations of a normal birth diverge from their experiences, a shift occurs in their birth discourses. In their narratives, women revealed contradictory positions and did not necessarily articulate their original belief orientations relating to natural birth discourse.

Normal birth discourse produces a position based on the ascribed attributes of childbirth as a natural event (Romano & Lothian, 2008). Women's ascribed characteristics evoke certain

moral roles, duties, and obligations that often discount individual and subjective experiences (Harré, Moghaddam, Cairnie, Rothbart, & Sabat, 2009). However, the caesarean birth is a transformative experience that marshals ideological and positional shifts and produces a new autobiographical and social sense of selfhood (Davies and Harre, 1990). The significance of this shift is seen in women actively seeking biomedical understanding of their bodies and childbirth.

The concept of positioning in the social psychology field articulates the dynamic sense and fluidity of self-identity. Through interactions and discourses, multiple meanings of the embodied self are actively constructed to reflect both interactive and reflexive ideological shifts (Davies and Harre, 1990). From the point of women's behaviours and perspective, the concept of positioning considers the micro circumstances between women and their relationship with the other actors within the maternity setting. However, it does align with the wider theoretical framing that unpacks the broader discourses of categorisation that are crucial in the ascribing of roles. Womanhood on its own brings with it an extensive categorisation and ascribed attributes, duties, and obligations that appeal to the gendered nature of feminine constructions (Zahra, 1990). In the gender political discourse, we often observe that this categorisation of womanhood goes beyond 'being a woman' as a politically significant gender-based category but embeds within its discourse the notion of 'womanhood' as an attribute of the individual woman (King, 2004). The latter categorisation (as with the former in some ways) has historically been a tool for the subjugation and control of women.

Feminist poststructuralist theory opposes the notion of the 'self' as structurally static, leaving little room for changes to subjective positions produced through social interaction, learning, and discourse (Davies and Harre, 1990). Davies and Harre believe that "an individual emerges through the processes of social interaction, not as a relatively fixed end product but

as one who is constituted and reconstituted through the various discursive practices in which they participate" (1990, p. 46). On this premise, the understanding of the discursive ambiguity in women's narratives is allocated meaning. It was evident that the meanings that women gave to their experiences implied commitment to the social context upon which such meanings were constructed and the spoken practices which women invoked implicitly or explicitly, rather than on their affiliations with and in relation only to specific ideological discourses. Through this 'unfolding narrative', new subject positions are observably constituted within the women's experiences, and previously articulated positions were renegotiated, and normalised discourses were challenged.

There was a strong consensus among the care providers of the recovery-related benefits to the woman of post-discharge consultations/debrief with operating surgeons after an unplanned CS. The midwifery and feminist literature on post-birth reflective dialogue have historically focused on the need for women and their midwives to create a space for reflective conversations that support women to share and discuss their childbirth experiences (Waller, 2019). For the women in this study, who experienced an unplanned and emergency CS, the expectations fell on community midwives (LMCs) alone to create these spaces. While this aspect of the continuity of midwifery care can help in mitigating against adverse reactions from the abrupt transfer of care and the experience of traumatic obstetric birth (Grigg, Tracy, Schmied, et al., 2015), what most women found surprising was that doctors are left out of this dialogue.

Though women prefer to have post-birth discussions with their community midwives rather than with doctors (Cox, 2007), women's values and preferences for the content and format of information about their childbirth not only vary across a population and social systems, but also evolve or are subject to change on an individual basis (Kingdon, Downe, & Betran,

2018). Women were determined to discuss with the doctors' aspects of their caesarean experience, such as their physical recovery, review of issues around their intrapartum care, and the implications of the CS on future pregnancy and childbirth decisions. However, they felt that opportunities for this were deficient in the current system of maternity care. Though community midwives often have these types of discussions with their clients, research shows that for women who experience operative deliveries, such dialogue may be less effective under isolation from obstetric input (Small, Lumley, Donohue, Potter, & Waldenström, 2000; Wen et al., 2012). Understandably, when midwives transfer care to doctors, there is official recognition that doctors have the expertise in obstetric complications. Therefore, when women seek to understand and regain a sense of control over their birth conditions, they seek this from those they perceive to have the power and knowledge. Therefore, seeking debriefing with doctors appears to be how women aim to achieve both physical and emotional meaning-making from their birth experience. It was to know what happened and possibly why and to obtain some sense of what this might mean for the future, thereby forming a more comprehensive narrative account.

7.10. The notion of autonomy, informed consent, and expectations of shared decision during emergency operative deliveries

The concepts of autonomy, choice, informed consent, relational, and shared decision-making were emphasised as necessary by women in their birth and experience of unplanned CS specifically. These concepts are also acknowledged as fundamental in healthcare practice and policies in Western cultures (Beckmann, Cooper, & Pocock, 2015; Begley, Daly, Panda, & Begley, 2019; Goldberg, 2009; Yuill, McCourt, Cheyne, & Leister, 2020). The findings show

that consent to perform an unplanned caesarean section is affected by three key factors: women's safety concerns, their fear of harm to the unborn child, and care providers' influence.

Women operated within the discursive constructions of care providers (doctors and midwives). Their embodied experiences were negotiated and established as they contended with the polarity of midwifery care compared to a highly technocratic obstetric experience. These findings align with previous research on women's perceptions of decision-making for an unplanned caesarean section (Meric et al., 2019; Sakala, Belanoff, & Declercq, 2020; Tully & Ball, 2013). The findings further highlight the ambiguity and bio-political nature of reproductive technologies used during labour and childbirth. From a feminist ethics standpoint, reproductive technologies can promote autonomy and choice for childbearing women (Purdy, 2006). Yet, more cynically, it constitutes a calculated means of technologically mediated surveillance of the maternal reproductive body (DeSouza, 2014; Tremain, 2006). Such technologies support a hierarchical investment of decision-making authority in medical professionals rather than women (Davis-Floyd, 1993; 2001).

The process of decision-making can become heightened when unexpected complications occur during labour and childbirth, and the severity of the complication can impact how the concept of autonomy, informed decision, and consent are observed and negotiated between care providers and maternity care users (Noseworthy et al., 2013). While women in the study acknowledged that care providers recognised their rights to give consent for caesarean birth, most were dissatisfied with not being fully involved in the decision-making process. There was concern that decision-making was dominated by professionals' views rather than women's preferences and informed choices. Women identified clinical obstetric knowledge as the most crucial element that facilitates the obstetricians' domination in decision-making.

Hence, women described themselves as passive participants in the process, relying primarily on the experts to decide their fate. For a minority of the women interviewed, relinquishing this responsibility to obstetricians was a relief, and obstetricians' concern for the baby and safety first typified obstetric professionalism.

A poststructuralist feminist perspective informs an analysis of the nuances of clinical decision-making (Arslanian-Engoren, 2002). The power of obstetric knowledge and the submissiveness of women is a common experience during obstetric encounters (Davis & Walker, 2010; Kathleen Fahy, 2002). Power represents the capacity to achieve the desired outcome; through behavioural conformity and decision-making (Buse, Mays, & Walt, 2005). Foucault noted that power and knowledge are inseparable. They are interrelated and strengthen each other (Foucault, 1980). According to Foucault, medical power operates as disciplinary power (see section 7.3 for further discussion), which is often subtle, non-repressive, normalised, and requires the cooperation of its subjects, usually due to the expectation of reward or fear retribution (Fahy, 2002). The ability for care professionals to influence women's preferences concerning their childbirth demonstrates the thought-controlling dimension of power. Foucault described how power dynamics play out in a hierarchical relationship, where the knowledgeable (expert) exerts power over the lay individual (the less knowledgeable) (Foucault, 1980). Obstetric professionals have positioned themselves as experts in childbirth through formal education and institutionalisation. Thus, they exercise authority and influence. Doctors' training and knowledge around medical emergencies are identified as the key element accounting for women's trust in doctors' recommendations (Konheim-Kalkstein & Miron-Shatz, 2019). This was reflected in the participants' narratives, in their descriptions of how the authoritative language used by professionals to describe their situation and make recommendations for care undermined their

own agency. Though, most woman felt reassured by their midwives' concurring with the decision for intervention.

Language constitutes the key constructs such as masculinity, femininity, and normality and can be a medium through which power and knowledge establish positions within cultural and socio-political institutions (Weedon, 1997). The language of risk dominated doctors' discourse with women. Participants perceived this as focused more on avoiding harm to the unborn child than meeting their birth aspirations. Such a focus can amplify the power imbalance in the women-doctor encounter, where women's decisions become subject only to the information provided by doctors (Fochsen, Deshpande, & Thorson, 2006). This focus also narrows professionals' recognition/respect of women's autonomy in giving consent for the medical intervention. Such realities reinforce an ideology that overlooks women's views, minimises their autonomy, and alter perceptions of informed choice (Noseworthy et al., 2013; Vedam, Stoll, Martin, et al., 2017). This emphasises the importance of dialogue as a central concept in the feminist poststructuralist analysis being a two-way conversation and communication, involving listening to women's views, thereby reducing gender disparities in healthcare decision-making processes (Arslanian-Engoren, 2002).

Care providers' accounts also highlight their view of the foetus as a separate patient to the mother, consistent with Brione, (2015). This perspective impacts care providers' views of the weight/importance of women's autonomy in decision-making. When women's birth aspirations conflict with the safety of the foetus, this can determine the extent to which physicians are willing to engage with the woman or respect their preferences. In such circumstances, care providers can use a range of strategies, including intrusive language, to communicate urgency and persuade women to agree to recommended care (Jenkinson et al., 2017). Therefore, women's preference around their childbirth may be considered secondary

needs, while safety and avoidance of harm to the child become the focus of the clinical decision (Sullivan, 2006). This is not unreasonable, as the women interviewed also spoke of their key concern of ensuring their child's safety over their choice and birth preference. The burden on the women to make the right decision when consenting to a CS was accompanied by a range of emotions that varied from hope, doubt, and fear of making the wrong decision that potentially puts the unborn child's life in danger. An unplanned CS was, therefore, less of an expression of autonomy, and more a response to a sense of 'obligation' women felt to ensure the safety of their child. Consistent with Foucault's conceptualisation of power, medical discourse and thought/behaviour control, the power ascribed to obstetricians to make life and death decisions were apparent and produced a compelling, indeed inarguable, rationale for CS.

Despite women's perceptions that obstetricians hold more power around decision-making for caesarean section, the roles of midwives were also acknowledged and perceived as vital, suggesting that both obstetricians and midwives are key actors that influence women's decision-making. Midwives often served as the nexus between women and obstetric specialists in the hospital and play essential roles in risk classification (Panda, Daly, et al., 2018), ensuring that women are supported, promoting the teamwork process. It was interesting to note that, despite midwives' roles in the decision for medical intervention (from initial referral to supporting obstetricians' decisions), most women viewed their midwife LMCs in the decision-making process positively compared to how they viewed the roles of doctors. This may be due to the language use and the relational manner in which community midwives communicate with their clients, and the trust relationship that typifies the midwife-woman relationship (Berg, 2005; Lundgren & Berg, 2007; Perriman et al., 2018). The concept of trust between women and the care professionals involved in their care is seen to

strengthen the midwife-woman relationship and be important in influencing women's decision-making about their maternity care.

7.11. Strengths and Limitations

The research findings were based on qualitative methodology and in-depth interviews and focused on the meanings and interpretations women construct about caesarean birth experiences. The interviews enabled qualitative interactions between the participants and I, which produced a dynamic and open conversation, and enriched the research data. Qualitative approaches are well suited for exploring experiences, perceptions, and attitudes (Becker et al., 2012). Interviews or qualitative approaches more generally, is also useful in the analysis of demographic and health behaviours (Foley & Timonen, 2015; Obermeyer, 1997). However, like other qualitative studies, the aim of the research was not to claim sample representativeness nor generalisability of the research findings. Therefore, the findings of this study are limited to the research participants, though the research represented a broad range of women's birth experiences. As the research relied solely on women's voices and their lived experiences, the research provides greater insight and in-depth understanding of women's subjective experiences of caesarean section, and the impact on their lives. This has key feminist relevance and wider public health implications.

In NZ, the norm is to birth at a primary birthing unit, and women are often discouraged from birthing in the hospitals, particularly if they are considered low risk. Primary birth is promoted as the 'normal' from a health system perspective due to the cost implication of birthing in a hospital. Hence, there is that social element of expectation that cuts across NZ and is a key discussion in the current research. Also, right across NZ there is the debate of the

maternity system being under pressure. As reported in this study and elsewhere, issues of inadequate resources are barriers to equitable maternal health (Dawson, Jaye, Gauld, & Hay-Smith, 2019), highlighting how the findings in this research apply within the broader NZ context.

While races and experiences are different, women's struggles, even in maternity care are universal (Stone, 2004). Furthermore, the social challenges highlighted in this research are similarly reported in the wider literature. Therefore, I argue that this research has presented robust information to allow for the argument of transferability in international settings.

The participation of care providers in this study was essential for the advancement of the research findings. As experts and leaders of maternity care services, with in-depth knowledge of both the research topic and the general operation of the maternity system, care providers' views provided an understanding of the nature of care and support services for women who have CS, and the scope of post-natal support for them. However, only a small sample size of obstetricians was interviewed, thus, may not represent majority view of obstetricians within the maternity system. Difficulty recruiting physicians in is a common phenomenon in health research (Asch et al., 2000; Herber, Schnepp, & Rieger, 2009; Johnston et al., 2010b, 2010a). Efforts to get more doctors to participants in the research were unsuccessful. Despite their small number, the participation of obstetricians in the current research was crucial to investigating issues concerning best practices, guideline operations, quality of care, and access within the New Zealand maternity system.

Chapter Summary

This research has discussed how non-human elements such as procedural, interactive, environmental, and policy informed the meaning and interpretation of women's experiences. Power is a critical element in policy-making, and research has increasingly drawn attention to the importance of policy to understanding power (Brown, 2015; Gore & Parker, 2019; Mwisongo, Nabyonga-Orem, Yao, & Dovlo, 2016; Shiffman, 2014). However, this reality can often be ignored in health policy analysis, mainly where the emphasis is on scientific evidence as to the basis for decision-making and care processes (Gore & Parker, 2019). Adopting theoretical approaches such as poststructuralism in health policy and system analysis allows for the theorising and understanding how power and its mechanisms are implicated in and permeate policy processes. In many instances in health care systems, policies can set or reinforce professional boundaries. For example, research has identified how widening professional boundaries between midwives and obstetricians in maternity care can impact the scope of midwifery practice, consequently leaving midwives less visible and feeling less confident about their roles (Hunter & Segrott, 2014). For example, when a woman's care is transferred from the midwife to hospital specialist, the midwife remains the lead maternity carer. However, she has no obligation to maintain a physical presence during the woman's caesarean birth according to the Section 88 *Primary Maternity Services Notice 2007* practice guideline of LMC services (Ministry of Health, 2007). Women seemed confused about this reality. While the woman continues to receive adequate care from the hospital team, the emotional, sensitive, and relational care she enjoys from her community midwife, which she anticipates for her childbirth, is often unassured.

NZ midwifery-led model of continuity of care is recognised internationally as unique. The guiding policy sets a timeline of four to six weeks of postnatal midwifery support for NZ

women after birth. Though, the period of recovery for most women after an operative delivery may be extended. In these instances, it is evident that the care for women during/after an emergency caesarean section is shaped by the broader organisational policies, practices, and set structures, and less by individual women's experience and care needs. Although some basis in clinical judgements of what would be the ‘average recovery time’. The implication of this is that there is the potential for women’s views about their care to be overlooked and their physical, psychological and emotional well-being negatively impacted.

Chapter Eight: Conclusion and Recommendations

The assumptions and expectations that women assemble and construct about childbirth can affect how they respond to a childbirth experience that deviates from a preconceived ideal (Frost et al., 2006; Gibbins & Thomson, 2001). The findings make visible how professionals' discursive constructions and the associated philosophies of midwives or other professionals and the 'lay' perspectives from antenatal classes and in everyday conversations with family and friends influence women's birth constructions. Through a poststructuralist lens, this research has demonstrated that birthing philosophies and antenatal care, including classes, shape women's birth expectations and their corresponding perceptions and satisfaction of an unplanned caesarean section. It was evident that the ways providers conceptualise and communicate what birth is and how birth should proceed play an essential part in setting women's expectations of childbirth, and their responses to an unplanned CS.

Constructed expectations are an important part of childbirth preparation (Gibbins & Thomson, 2001; Hildingsson, 2015; Preis, Lobel, & Benyamini, 2019). While women may construct ideal expectations of what they would like in their labour and childbirth, these expectations in childbirth are often different from their experience, as this study's findings indicate. Where expectations are unrealistic and significantly different from subsequent experiences, they can negatively recollect birth experiences. This is particularly the case when discourses around birth expectations are constructed as the 'norm' (Walsh, 2010). For example, this research showed that hope of immediate skin-to-skin contact (SSC) after birth is an important expectation for most mothers. Though, in an emergency CS, this expectation is often not realised, in many cases, due to institutional protocols around post-caesarean infant care. Irrespective, there is a predominance of research based on the premise that SSC is a critical factor for breastfeeding and other positive outcomes such as improved maternal-

infant bonding, increased maternal satisfaction, and neonatal metabolic and cardiovascular stability (Aghdas et al., 2014; Badr & Zauszniewski, 2017; Elsaharty & McConachie, 2017; Guala et al., 2017; Hung & Berg, 2011; Moore, Bergman, Anderson, & Medley, 2016; Şimşek & Karahan, 2017; Smith et al., 2008). The potential that promoting immediate SSC can counter the adverse effects of unplanned CS among women is suggested in this research. Therefore, it is crucial that health professionals caring for women undergoing an unplanned and emergency CS endeavour to make the experience more woman- and family-centred. For example, making operating rooms more family-friendly, promoting early skin-to-skin contact between the woman and her newborn, and encouraging family support during the CS.

This thesis demonstrates how the transfer of care results in a disruption of midwifery continuity of care. Though this disruption is only temporary, the impact on women is significant and can contribute to dissatisfaction with the maternity experience. The research findings have highlighted ways that the effects of this disruption can be lessened and how women's experiences can be improved. The discussion of the hypothetical possibility of transfer with women in the antenatal period and during labour by midwives in a supportive and sensitive manner is an important step to help women manage their expectations and adjustment when the transfer takes place. This is also crucial as the experience of complicated or prolonged labour may compromise the expectant mother's capacity to process information, which might impact informed decision-making when abrupt changes occur.

Women and midwives' perceptions of obstetricians' positions, knowledge, power, skills, and expertise continue to influence women's decision-making and consent for a caesarean section when difficulties arise during labour. Despite midwives' philosophy of promoting natural (vaginal) birth, this thesis shows that midwives play an important role in women's access to a CS. Midwives prevent adverse situations by recommending and processing referrals to

hospital obstetric specialists and affirming support during the decision-making process. This role of midwives, unlike doctors, is mainly perceived by women as supportive rather than as 'influence'. While this is important in terms of women's perceptions of involvement in decision-making, midwives need to be cognizant of their position of power and how this can impact women's decision-making. Regardless, obstetricians' perceptions and eagerness to manage/avoid potential adverse events can act as a factor that influences the decision for an unplanned CS. While women's access to obstetric care can promote their agency and choice around their reproductive health, when doctors recommend a CS during prolonged labour, there is a need to ensure informed consent. Since women's relationships with doctors remain unequal, in the decision for an unplanned CS, the doctor's authority and power always influence the woman's choice (Panda, Begley, et al., 2018; Panda, Daly, et al., 2018; Peel et al., 2018). In the 'life or death' domain of an emergency CS, women's agency/autonomy makes way for informed choice/consent. Therefore, clinical decision-making approaches must incorporate and ensure sensitivity to women's views even in obstetric emergencies. Respectful, relational, and reflexive behaviours of care providers can improve women's perceptions of active involvement in decision-making during labour and childbirth. This can foster women's sense of control over their decisions and improve outcomes for the mothers.

This thesis drew on Foucault's discussion of knowledge and power to apply analyses of governmentality surrounding birth discourses within the context of a midwifery dominated health system. The thesis contributes an understanding that while the techniques of governmentality remain constant, the sense of individual responsibility that accompanies natural birth discourses elicited emotions of guilt and disappointment among women.

Through poststructuralist discourse analysis of antenatal and birthing practices, the research uncovers how the meanings that women construct around a caesarean birth experience

generate new discursive spaces and consciousness. Mothers were challenging socially-mediated hegemonic childbirth narratives that essentialise birthing processes, and maternal subjectivities. The discursive resistance by the mothers in this study contributes to an understanding of how the assemblage of knowledge discourses can be integrated in a transformative way to connect maternal, professional, and institutional knowledge domains. This can inform productive conceptions of fluid conceptualisations of care that recognises and accepts the multiplicity in meaning/knowledge production.

Every woman experiences labour and childbirth uniquely. However, personal experiences of childbirth in most Western countries are mainly subject to the competing ideologies of biomedical and natural birth discourses. In the narratives of women's experiences of caesarean birth, much emphasis remains on the implications for the increasing medicalisation of birth, often resulting in the construction of caesarean section as the 'undesirable'. These discursive practices are, in many cases, established within professional discourses and has shifted the discourse of CS from a life-saving medical operation and health perspective to a social critique (Tully & Ball, 2013). To enhance the culture of responsiveness among carers, a further cultural and professional shift is necessary. It is vital to acknowledge the extent to which competing birth discourses create ideological boundaries that do not serve women's interests. Instead, it contributes to the polarisation of both paradigms, where natural birth is considered 'normal' and medicalised birth is viewed as 'abnormal'. Therefore, the findings of this research build on the theoretical understanding of caesarean section as part of the dimensionality of childbirth experiences. Such recognition and conceptualisation offers a way out of the dilemma between the different birthing philosophies and is helpful to both women and their care providers. A feminist poststructuralist approach considers that established disciplines will only advance ontologically and strengthened epistemologically by being

receptive to new ways of thinking and challenging traditional modes of knowledge production. This important attribute of the poststructuralist feminist approach is vital for the advancement of the theory.

8.1. Recommendations from the research findings

The findings of this research have many implications for childbearing women and their families, care providers, and the wider health care system. The findings can inform changes in antenatal, prenatal, and postnatal services that can help improve women's unplanned and emergency caesarean section experiences and potentially reduce the impact of trauma for women during and after unplanned CS.

8.1.1. Recommendations for antenatal preparation, birth literacy, and the wider healthcare setting

This study demonstrates how prenatal education influences women's perceptions of childbirth. When antenatal educational content does not reflect women's birth experiences, this can negatively affect experiences of postnatal health services (Murphy, Pope, Frost, & Liebling, 2003). The findings from this research suggest that operative interventions are not adequately addressed by current antenatal preparation. Women must receive adequate information to help them construct realistic expectations about labour and childbirth through continuous communication with care providers about the fluidity and unpredictability of labour and childbirth. This is crucial in narrowing the gap between expectations and

experiences and will potentially improve satisfaction with labour and birth outcomes even when things do not go according to plan.

Discussions about caesarean section should be a part of childbirth education and antenatal consultations with midwives. While this may exist amongst some educational providers, the findings in this study show that this is ot typical, and most women miss out on this vital information.

Antenatal classes must expose women to the true breadth of ‘normal’ experiences of birth which range from the ‘textbook-perfect birth to a traumatic caesarean section experience. Also, it will be beneficial to women and their families by including obstetricians in designing antenatal classes and their contents, rather than the contents captured by one profession or philosophy.

Furthermore, the lack of clarity for women regarding the clinical responsibilities and understanding of legal stipulations of their LMC suggests that communication issues do not only exist between the midwife and her client and family but speak to levels of health regarding the maternity system. The findings provide an opportunity to expand the scope of labour/birth literacy for women and their families (Renkert & Nutbeam, 2001). This comes down to individual conversations about how the maternity system works, for example, within antenatal classes. This clarity can help prevent distrust in the system and reduce the confusion and anxiety associated with the transfer of care.

This research also identified important physical and psychological care issues women face after an unplanned CS and the impact on the mother-infant postnatal wellbeing. The findings can contribute to midwifery and obstetric practice by raising awareness among midwives and

obstetricians about the distress women may face and how they can better support women under their care who have unplanned CS.

8.1.2. Recommendations for postnatal care

In the discussion for postnatal care, both women and care providers identified post-discharge follow-up from specialists as a missing service in the public system which is essential for optimal postnatal care for women after an unplanned CS (Dougan, Smith, Ploski, Mc Nally, & Johnston, 2019). Improving the current system may require the public sector to follow the private model where, as part of postnatal care service after an unplanned CS, women are seen by their obstetricians for debriefing weeks after their planned CS and care from their community midwives. This would address flawed understandings of why the emergency caesarean section was needed and create an opportunity for women to express any challenges, concerns, or fear concerning their recovery. Doctors can discuss with women the implications of their CS for their postnatal well-being and possibilities for birth options in a future pregnancy.

Multidisciplinary support around post-surgical care after CS involving midwives and obstetricians could promote cross-fertilisation of skills and expertise and create an opportunity for shared learning. This can be facilitated by ensuring that there is direct communication between the care providers. This will ensure consistency in information dissemination, foster a team approach, and promote woman-centred care. Also, women can benefit from being supported to make decisions in their subsequent pregnancy and childbirth based on informed choice. This can help control the chances of developing postnatal stress and anxiety following an unplanned and emergency CS.

8.1.3. Recommendations for future research

There is a paucity of qualitative research on women's experiences of unplanned and emergency CS. Future studies can investigate the impact of women's social and cultural backgrounds on their experience and perception of unplanned CS.

Based on the findings from this research, it is evident that despite the increasing rate of caesarean section in New Zealand, women still lack adequate information about CS. Given the importance of antenatal education on health literacy for expectant mothers and their families, more research looking into comprehensive antenatal education and women's adequate preparation for unpredictability in labour and childbirth is encouraged. Research highlighting the appropriateness of caesarean delivery may help reduce stigma and women's perceived need to justify decisions for a caesarean birth. Identifying how these dynamics impact women's recovery is a worthwhile goal for new studies.

Women identified many postnatal health-related issues such as pain complications, restricted mobility, postoperative infection, poor sleep quality, and difficulties in breastfeeding that hinder their recovery and nurturing of their neonates. Despite a few studies in these areas, longer-term recovery-related experiences after CS remain underexplored. There is a need for future research to explore new ways to provide recovery-related information to women to ease access to support services to aid their recovery.

Though previous studies have discussed women's experiences transferring from midwife-led to obstetric-led care, there is still little understanding among women of clinical responsibility and expectations of LMC roles during caesarean operation. Future studies can extend this understanding by building on the findings from the present study.

Much of the notion of ‘resistance’ to hegemonic discourses have often focused on biomedical discourses and interventionist birth in previous research. An important finding in this research is women’s acceptance of biomedical and interventionist discourses and questioning the pervasiveness of natural birth discourses drawing from their deviant experiences. However, the ‘natural’ discourse extends beyond birth to attachment and parenting – so women who experience CS do not reject ‘natural’ discourses entirely. Understanding how women acknowledge and situate their caesarean delivery within the enduring natural birth discourses requires further evaluation of women’s embodied experiences.

8.2. Reflections on my PhD journey

I found that my research insight was valuable in shaping my personal experience of accompanying my wife through her pregnancy, childbirth, and the experience of the NZ maternity system. The experience of becoming a father deepened my research insight and, in some ways, helped me better appreciate the lived experiences of my research participants. I recall being the bearer of the ‘not so favourable information’ during our birthing class, where one of the couples in my class had asked the instructor her views on caesarean section. The instructor was unsure of the current rate in New Zealand but suggested that the rate would be low. I shared what I had learned from the literature and my findings from the interviews, informing the class that one in four women in New Zealand gives birth by CS, with about 50% of this number unplanned. At that point, I was unsure if I had done the parents a favour by sharing this information or if I had succeeded in scaring them to their toes. It was interesting to see the women asking questions about CS and wanting to know more.

I recall an incident at the hospital the day my son was born. My wife was going through a lot of pains and, at some point, was considering requesting an epidural. However, she had informed me earlier that she would prefer not to use an epidural during labour, so I had to remind her of this. A doctor in the maternity ward who had heard this was unhappy and asked, "what right I had to stop her from getting the epidural"? I was sure I had not stopped my wife but only reminded her of what she had discussed with me. Our midwife LMC was supportive of reminding my wife what she wanted and helping her to achieve that. After birth, my wife was happy she did not use the epidural but opted for other alternative pain relief options. In retrospect, I wonder if the doctor was trying to protect my wife's interest. Yet, how could this be if she barely knew her?

My experience was not without its challenges. Our breastfeeding support experience in the hospital and back home was almost non-existent and perhaps impacted my wife developing post-partum depression, primarily due to her inability to breastfeed naturally. With an LMC who was kind, supportive, and always willing to listen to our views, I am inclined to say that my personal experience and that of my wife of the NZ maternity system was generally satisfactory.

This thesis has been four years in the making, with twists and turns along the way. Besides coming into my role as a new father, my greatest challenge has been coping with deep losses, losing my father (father-in-law), taking care of a distraught wife, and dealing with the loss of a pregnancy consecutively attempting to remain sane and somewhat productive. I had great hopes towards the end of a monumental effort to complete my thesis at the start of the year. Getting to this point has been a struggle, and it pleases me to say, finally, I made it through!

To anyone struggling, you are not alone. If you just keep pushing, one moment at a time, you will get there, just like I did. To the wonderful ladies who trusted me to share their stories, I am most grateful to you and your journey. Love and light!

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Appendix 1: Official information act request Ministry of Health

MINISTRY OF HEALTH
MANATŪ HAUORA

133 Molesworth St
PO Box 5013
Wellington 6145
New Zealand
T+64 4 496 2000

0 3 JUL 2019

Charles Egwuba

By email: fyi-request-10572-079992df@requests.fyi.org.nz
Ref: H201904275

Dear Mr Egwuba

Response to your request for official information

Thank you for your request of 12 June 2019 under the Official Information Act 1982 (the Act) for:

> *"I wish to request for information on the current rates of*
> *1. caesarean section, in New Zealand and Canterbury (2018)*
> *2. unplanned or emergency caesarean section, in New Zealand and Canterbury (2018)*
> *3. Number of total registered live births in 2018 in New Zealand and Canterbury (2018)*
> *This is information request is for my PhD study."*

A copy of the Report on Maternity 2017 and an excel spreadsheet of the accompanying tables are publicly available to download from the Ministry of Health (the Ministry) website: https://www.health.govt.nz/publication/report-maternity-2017.

Table 35 in the accompanying table's spreadsheet, shows the number and percentage of emergency caesarean sections by district health board of residence between 2013 and 2017. Table 36 shows the same information but for elective caesarean sections. There were 60,455 live births registered in New Zealand in 2017.

Please note, this is the most recent information held by the Ministry, the updated Maternity data will be published on the Ministry's website next year.

I trust this fulfils your request. You have the right, under section 28 of the Act, to ask the Ombudsman to review any decisions made under this request.

Please be aware that this response (with your personal details removed) may be published on the Ministry's website.

Yours sincerely

Shayne Hunter
Deputy Director-General
Data and Digital

Appendix 2: Official Information Act request CDHB 10123

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

CORPORATE OFFICE

Level 1
32 Oxford Terrace
Christchurch Central
CHRISTCHURCH 8011

Telephone: 0064 3 364 4160
Fax: 0064 3 364 4165
carolyn.gullery@cdhb.health.nz

2 July 2019

Charles Egwuba

Email: charles.egwuba@pg.canterbury.ac.nz

Dear Charles Egwuba

RE Official Information Act request CDHB 10123

I refer to your email dated 12 June 2019 requesting the following information under the Official Information Act from Canterbury DHB.

I wish to request information on the current rates of:

1. **Caesarean sections, in Canterbury (2018)**
2. **Unplanned or emergency caesarean section, in Canterbury (2018)**

There were 1830 caesarean sections performed in 2018. There were 953 elective/planned and 877 unplanned or emergency caesarean sections.

Please refer to Table one (below) for the details of unplanned or emergency caesarean sections in Canterbury during 2018.

Table one: Unplanned or emergency caesarean sections 2018

	Number
Emergency classical caesarean section	10
Emergency lower segment caesarean section	867

3. Total number of registered live births in Canterbury (2018)

Please refer to Table two (overleaf) for Canterbury DHB registered 'Live births' during 2018.

Table two: Registered 'Live births' in Canterbury 2018.

CDHB Live births	2018
Ashburton Maternity	123
Burwood Birthing Unit (Closed June 2016)	-
Christchurch Women's Hospital	5024
Darfield Hospital	1
Kaikoura Health Hub	9
Lincoln Maternity Hospital	167
Rangiora Health Hub	212
St George's Maternity (from Feb 2014)	457
Homebirths*	380
Grand Total	**6373**

* Canterbury's home birth rates have historically been difficult to capture. Prior to May 2017, home births were captured via the National Immunisation Register (NIR) meaning births where a parent opted their child out of the NIR were not included. From 1 May 2017 onwards homebirths in Canterbury were captured more accurately through the LinKids programme.

I trust that this satisfies your interest in this matter.

Please note that this response, or an edited version of this response, may be published on the Canterbury DHB website after your receipt of this response.

Yours sincerely

Carolyn Gullery
Executive Director
Planning, Funding & Decision Support

Appendix A: HEC Ethics Approval

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

HUMAN ETHICS COMMITTEE
Secretary, Rebecca Robinson
Telephone: +64 03 369 4588, Extn 94588
Email: human-ethics@canterbury.ac.nz

Ref: HEC 2017/96

20 November 2017

Charles GC Egwuba
Health Sciences
UNIVERSITY OF CANTERBURY

Dear Charles GC

The Human Ethics Committee advises that your research proposal "Women's Experiences of an Unplanned Caesarean Section Within New Zealand's Maternity System" has been considered and approved.

Please note that this approval is subject to the incorporation of the amendments you have provided in your emails of 29 October 2017 and 11 November 2017.

Best wishes for your project.

Yours sincerely

pp. R. Robinson

Associate Professor Jane Maidment
Chair
University of Canterbury Human Ethics Committee

Appendix B (1-3): Plunket Ethics Approval

1.

27 February 2018

Mr Charles Egwuba
School of Health Sciences
College of Education, Health and Human Development
University of Canterbury
Private Bag 4800
Christchurch

Dear Mr Egwuba

Women's experiences of an unplanned Caesarean Section within New Zealand's maternity system

The Plunket Ethics Committee has considered your application and has given it approval, but considers you should look closely at the following points:

1. You need to make contact in Plunket with either [redacted]@plunket.org.nz, Clinical Services Manager, or [redacted]@plunket.org.nz, Acting Regional Operations Manager. Discussions with them may clarify how best you recruit participants, including local newspaper and LMCs, and parent groups.
2. On the information sheet replace reference to 'mental illness' with 'any form of mental health issue.'
3. Under potential risks and burdens, you should also include contacts for local Early Intervention Maternal Mental Health Services, Postnatal Adjustment Program (PNAP, run by Plunket staff in Canterbury), and/or recommend participants access their GP.
4. Interview Questions for Maternity Care Users, consider the following:
   - Why are you asking about other complications?
   - Why are you asking about separation from your baby since there may not have been separation from the baby?
   - Replace support person with support partner.
   - Why ask about breastfeeding since this does not seem to be relevant to this study?
5. How many health professionals are you seeking to participate in the study?

Please feel free to respond to me directly at [redacted]@otago.ac.nz

Yours sincerely

[redacted]
Chair
Plunket Ethics Committee

In the first 1000 days we make the difference of a lifetime | Whānau āwhina

P 04 471 0177, F 04 471 0190
Plunket Support Office, Level 3 Simpl House, 40 Mercer Street, Wellington 6011
Plunket Support Office, PO Box 5474, Wellington 6140

2.

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

Ref: Plunket Application 2017 – Egwuba

Dear Gareth,

Thank you for the approval and your feedback and questions with respect to my Plunket ethics application for the study *"women's experiences of an unplanned caesarean section within New Zealand's maternity system"*. I have provided the answers below to address the raised concerns.

1. **On the information sheet replace reference to 'mental illness' with 'any form of mental health issue.'**

This change has been made

2. **Under potential risks and burdens, you should also include contacts for local Early Intervention Maternal Mental Health Services, Postnatal Adjustment Program (PNAP, run by Plunket staff in Canterbury), and/or recommend participants access their GP.**

This have been added to the section

3. **Interview Questions for Maternity Care Users, consider the following:**
   - **Why are you asking about other complications?**

This has been removed from the topic guide

   - **Why are you asking about separation from your baby since there may not have been separation from the baby?**

The question has been rephrased to "were you separated from your baby"? The response to this will then prompt the follow-up questions. The importance is to understand the impact of separation of newborns from their mothers on the women as reflected in available literature which suggest some form impact. This is important in light of the advantages of first contact between a mother and her newborn as evident in current literature

   - **Replace support person with support partner.**

This change has been made

   - **Why ask about breastfeeding since this does not seem to be relevant to this study?**

This question has been rephrased to "tell me about feeding and bonding with your baby". The emphasis is not on breastfeeding per say but on bonding between the mother and her newborn.

4. **How many health professionals are you seeking to participate in the study?**

I am seeking around 10 providers for the study, however, this number will be subject to data saturation.

Thank you.

Charles Egwuba

3.

Reply Reply All Forward IM

Wed 28/02/2018 12:01 PM

[redacted]

Re: Plunket ethics application - Charles Egwuba

To Charles Egwuba

Cc [redacted]@plunket.org.nz; [redacted]

You forwarded this message on 2/03/2018 2:18 PM.

Dear Charles

Women's experiences of an unplanned Caesarean Section within New Zealand's maternity system

Thank you for your responses to the questions raised by the Plunket Ethics Committee. You have answered them to my satisfaction. Please take this email as representing approval to proceed.

On behalf of the Ethics Committee I would like to wish you well for the study.

Regards

[redacted]

[redacted]
Chair
Plunket Ethics Committee
28 February 2018

Appendix C: Consent Form

Department: Health Sciences
Telephone: +64221220307
Email: charles.egwuba@pg.canterbury.ac.nz
Supervisor: Dr. Sarah Lovell
Email: sarah.lovell@canterbury.ac.nz

[WOMEN'S EXPERIENCES OF AN UNPLANNED CAESAREAN SECTION WITHIN NEW ZEALAND'S MATERNITY SYSTEM]

Please read and tick the following boxes if you are satisfied with the information provided and happy to partake in the study:

- ☐ I have been given a full explanation of this project and have had the opportunity to ask questions.
- ☐ I understand what is required of me if I agree to take part in the research.
- ☐ I understand that participation is voluntary and I may withdraw at any time without penalty. Withdrawal of participation will also include the withdrawal of any information I have provided should this remain practically achievable.
- ☐ I understand that any information or opinions I provide will be kept confidential to the researcher and that any published or reported results will not identify the participants. I understand that a thesis is a public document and will be available through the UC Library
- ☐ I understand that all data collected for the study will be kept in locked and secure facilities and/or in password protected electronic form and will be destroyed after 10 years.
- ☐ I understand the concerns associated with taking part and how they will be managed.
- ☐ I understand that I can contact the researcher [*Charles Egwuba* charles.egwuba@pg.canterbury.ac.nz] or supervisor [*Dr. Sarah Lovell* sarah.lovell@canterbury.ac.nz] for further information. If I have any complaints, I can contact the Chair of the University of Canterbury Human Ethics Committee, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz)
- ☐ I would like to review the transcript of my interview before publication
- ☐ I would like to receive a summary of the results of the project.
- ☐ By signing below, I agree to participate in this audio-recorded interview for this research project.

Name:_____ Signed:_____ Date:_____

Email Address:_____

Postal address *(for return of transcript & report of findings)*: _____

_____

_____

Appendix D: Recruitment Poster

Appendix E: Research Information Sheet (Maternity Users)

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

[WOMEN'S EXPERIENCES OF AN UNPLANNED CAESAREAN SECTION WITHIN NEW ZEALAND'S MATERNITY SYSTEM]

Information Sheet for Maternity Care Users

My name is Charles Egwuba, I am a PhD Candidate of the School of Health Sciences, University of Canterbury. Thank you for showing interest in this project. Kindly read the information sheet carefully before deciding whether or not to participate. Should you decide to participate in the study I thank you, however, there will be no disadvantage to you if you decide not to participate.

If you choose to participate in the study, you will be asked to voluntarily participate in an interview to be conducted by me or a female interviewer (should you choose this option), as part of my doctoral research.

Purpose of the research

The research seeks to investigate the experiences of women who have had an unplanned or emergency caesarean section in Canterbury New Zealand and the impact on their wellbeing and that of their families.

What type of Participants are being sought?

Women living in Canterbury (residents and citizens only), aged 18 years or older, who have had an emergency caesarean birth in the previous 3 months to 2 year period are being sought for this research. Approximately 20 women fitting this criteria are needed to participate in the research. Women who have been diagnosed before their childbirth or currently experiencing any form of mental health issue will not be eligible to participate in the study.

What will Participants be asked to do?

I am interested in hearing your views about your memory of your caesarean birth; decision making during labour, post-natal care, recovery and your experience adapting to motherhood.

Your participation is voluntary and you have the right to withdraw at any stage. You may ask for your raw data to be returned to you or destroyed within six weeks after the interview. If you withdraw, I will remove information relating to you.

Some people may find it difficult to talk about their birthing experience. You may stop the interview at any time for any reason. If you are upset or feel distressed by your experience, I suggest you contact a professional service such as LIFELINE on 0800543354 who can offer some assistance and give information on local counselling services. If you feel unhappy about the maternity care provided to you, contact the Health and Disability Advocacy Service on 0800555050, or the local Early Intervention Maternal Mental Health Services on 033779733, Postnatal Adjustment Program (PNAP, run by Plunket staff in Canterbury) on 033651646, and/or access your local GP to make your complaint and help you resolve your concerns. There are no other envisioned risks to you as a participant in in-depth interviews.

What data or information will be collected and what will it be used for?

With your consent, the interview will be audio-recorded and later transcribed for accuracy. Only the research team will have access to the audio-record and interview transcript. You may request to be interviewed by a female interviewer. If you choose to be interviewed by her, she will also have authorised access to the data. No real names or identifying information will appear in the findings of the research. **Should you decide to have the interview in your home, this will be expected to take place anytime between 10am in the morning and 4pm in the evening, any day of the week. You may also choose to have the interview alongside your partner or any other support person if you so wish.**

Data collected for the study will be kept in locked and secure facilities and/or in password protected electronic form and can only be accessed by members of the research team listed below. At the end of the project, any personal information will be destroyed, except any raw data on which the results of the project depend. This will be retained in a secured storage for 10 years, after which it will be destroyed in accordance with the University of Canterbury (UC) research policy.

The results of the project will be published in the form of a PhD thesis and articles for academic journals, but you may be assured of the complete confidentiality of data gathered in this research. Your identity will not be made public. To ensure anonymity and confidentiality, pseudonyms or codes only known to the researcher and supervisory team will be used to represent you. All personal information will be destroyed after the approved period. A thesis is a public document and will be available through the UC Library.

A copy of the interview transcript will be sent to you after transcription and a time period of 2 weeks will be allowed for you to review and make any changes if you wish to. The researcher will also make available to you a summary of the findings following the completion of the project.

Benefits

The benefits associated with participating in this study include those connected with sharing your birth stories, which can help you find new meanings to your birth experience. Your participation and sharing your experience can also be beneficial to many working in healthcare, as well as make a difference for others, as we get new ideas and information from the individual perspectives of women who have had emergency caesarean birth.

What if you have any questions?

If you have any questions or will like additional information about this project, either now or in the future, please feel free to contact any of the research team:

Charles Egwuba (Researcher)
School of Health Sciences,
University of Canterbury
Telephone: +64221220307
Email: charles.egwuba@pg.canterbury.ac.nz

Dr. Sarah Lovell, PhD (Supervisor)
Senior Lecturer | BHSc Coordinator
School of Health Sciences,
Level 2, Waimairi Building
University of Canterbury
Private Bag 4800, Christchurch 8140
New Zealand
Ph: 03 369 3576
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Annabel Ahuriri-Driscoll (Co-Supervisor)
Lecturer - Māori Health and Wellbeing
School of Health Sciences,
Level 2, Waimairi Building
University of Canterbury
Private Bag 4800, Christchurch
New Zealand
Ph: +64 3 3 693 516
Email: annabel.ahuriri-driscoll@canterbury.ac.nz

Appendix F: Letter to Providers

Charles Egwuba (Researcher)

School of Health Sciences,

College of Education, Health and Human Development

University of Canterbury

Telephone: +64221220307

Email: charles.egwuba@pg.canterbury.ac.nz

Name of Health Care Provider,

Address of Office

City, Region,

Dear Health Care Provider

My name is Charles Egwuba, I am a doctoral student at the University of Canterbury, School of Health Sciences. My doctoral research pertains to the experiences of women who have had an unplanned or emergency caesarean section in Canterbury New Zealand. Crucial to this study is examining whether the maternity system in Canterbury is perceived to be meeting the needs of women after an emergency caesarean delivery. To this respect, the research will also interview Lead Maternity Carers (LMCs) (midwives and/or obstetricians), practicing in Canterbury. LMCs are being recruited for the study due to their role in organizing and providing maternity care for women throughout pregnancy and birth.

I would greatly appreciate if you consider participating in the study. Should you decide to be part of the research, you will be asked to voluntarily participate in an interview to be conducted by me for no more than 1 hour, at a time and place convenient to you.

An information sheet which provides all necessary information about the research; your role, the procedure, your confidentiality and right to participate is also attached to this letter. Please feel free to contact me through the contact details provided for any question you may have.

Thanks for your time and kind regards.

Charles Egwuba

Appendix G: Research Information Sheet (Care Providers)

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha

[WOMEN'S EXPERIENCES OF AN UNPLANNED CAESAREAN SECTION WITHIN NEW ZEALAND'S MIDWIFERY-ORIENTED MATERNITY SYSTEM]

Information Sheet for Health Providers

Thank you for showing interest in this project. Kindly read the information sheet carefully before deciding whether or not to participate. Should you decide to participate in the study we thank you, however, there will be no disadvantage to you if you decide not to participate.

If you choose to participate in the study, you will be asked to voluntarily participate in an interview to be conducted by me as part of my doctoral research.

Purpose of the research

The research seeks to investigate the experiences of women who have had an unplanned or emergency caesarean section (CS) in Canterbury New Zealand and the impact on their wellbeing and that of their families. The study will also examine whether the maternity system in Canterbury is perceived to be meeting the needs of women after an emergency caesarean delivery.

The objectives of the research are to:

1. Investigate women's expectations of birth and their experiences of an unplanned caesarean birth.
2. Explore the impact of women's experiences of emergency caesarean on family development.
3. Explore the views of Lead Maternity Carers (LMCs) (midwives and/or obstetricians) on available support systems for women after an unplanned caesarean.
4. Examine how New Zealand's maternity system affects the birth experiences of women who have had an unplanned caesarean section.

What type of participants are being sought?

Lead Maternity Carers (LMCs) (midwives and/or obstetricians), practicing in Canterbury are being recruited for the study due to their role in organizing and providing maternity care for women throughout pregnancy and birth. Individuals have been identified through professional networks and telephone listings. We are seeking approximately 10 Health Providers to participate in the research. We are sending information about the study to health professionals by post and emails and following up with telephone calls.

What will participants be asked to do?

If you choose to take part in this study, you will be asked to participate in an in-depth semi-structured, face-to-face interview lasting no more than 1 hour. I am interested in hearing your views about the nature of care and support services for women who have caesarean delivery, in terms of essential perinatal and postpartum care needs. The interview will be conducted at a time and place that is convenient to you and may be in your office, home or a quiet space at the University of Canterbury.

Your participation is voluntary and you have the right to withdraw at any stage. You may ask for your raw data to be returned to you or destroyed within two weeks after the interview. If you withdraw, I will remove information relating to you, however, once analysis of raw data starts, it will become increasingly difficult to remove the influence of your data on the results. You may stop the interview at any time for any reason. There

are no envisioned risks to you in any form as a participant in in-depth interviews.

What data or Information will be collected and what will it be used for?

With your consent, the interview session will be audio-recorded and later transcribed so that we can identify important ideas emerging from the interviews. Only the research team will have access to the audio-record and interview transcript. No real names or identifying information will appear in the findings of the research, except in the identification of the institution or organization under which your practice operates.

Data collected for the study will be kept in locked and secure facilities and/or in password protected electronic form and can only be accessed by members of the research team listed below. At the end of the project, any personal information will be destroyed, except any raw data on which the results of the project depend. This will be retained in a secured storage for 10 years, after which it will be destroyed in accordance with the University of Canterbury (UC) research policy.

The results of the project will be published in the form of a PhD thesis and articles for academic journals, but you may be assured of the complete confidentiality of data gathered in this research. Your identity will not be made public without your prior consent. To ensure anonymity and confidentiality, pseudonyms or codes only known to the researcher and supervisory team will be used to represent you. All personal information will be destroyed after the approved period. A thesis is a public document and will be available through the UC Library.

You can request a copy of the interview transcript and make any changes if you wish to. A time period of 2 weeks will be allowed for this. Please indicate to the researcher on the consent form if you would like to receive this, and also a summary of the findings following the completion of the project.

What if you have any Questions?

If you have any questions or would like additional information about this project, either now or in the future, please feel free to contact any of the research team:

Charles Egwuba (Researcher)
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University of Canterbury
Telephone: +64221220307
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Dr. Sarah Lovell, PhD (Supervisor)
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School of Health Sciences,
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Private Bag 4800, Christchurch 8140
New Zealand
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Email: sarah.lovell@canterbury.ac.nz

Annabel Ahuriri-Driscoll (Co-Supervisor)
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University of Canterbury
Private Bag 4800, Christchurch
New Zealand
+64 3 3 693 516
Email: annabel.ahuriri-driscoll@canterbury.ac.nz

This project has been reviewed and approved by the University of Canterbury Human Ethics Committee, and participants should address any complaints to The Chair, Human Ethics Committee University of Canterbury. Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz). If you agree to participate in the study, you are asked to kindly complete the consent form and return it to the researcher via email, or in person at the time of the interview

Appendix H: Topic Guide (Maternity Users)

Department: Health Sciences
Email: charles.egwuba@pg.canterbury.ac.nz
Supervisor: Dr. Sarah Lovell
Email: sarah.lovell@canterbury.ac.nz

Interview Questions for Maternity Care Users

Research Question: What are the expectations of birth and the experiences of the maternity health system among women who have had an unplanned caesarean section in New Zealand?

	QUESTIONS	PROBES
Memory of your caesarean birth	What were your expectations of birth and how did your experience compare?	How did that make you feel?
	Share with me the memory of your labour leading to your caesarean birth	
	"What do you remember of the caesarean section and what was going through your mind as it happened?"	Can you tell me about the point where you understood you needed an emergency caesarean and how this made you feel? Were there other complications during the caesarean delivery that you remember?
	Was there any separation from your baby? Tell me about your first contact with your baby.	For how long? What was the nature of the separation? How did you feel about the separation from your baby?
Decision making during labour	Tell me about decision making around the caesarean birth, how involved were you with making decisions?	Looking back, how comfortable were you with the decision for a CS birth? Was your partner or support person allowed in the operating room? Did you request for this?

Satisfaction with service delivery	Tell me about your satisfaction with your LMC and other health worker's performance and behaviour	
Post-natal care and support	What are your views about the support and care you received after your caesarean delivery How long were you at the hospital? How often were you visited by your LMC or other care workers? What was the nature of postnatal follow-up? Tell me about the physical and mental support you received after the CS	Who was supportive during the procedure Did you feel you needed more hospital stay? Did you feel you needed more attention? Do you feel you understand why you had the caesarean section?
Recovery experience	Share with me your experience around physical and emotional recovery Tell me about the support you received after the birth. Share with me your views around your partner's support Was there difficulty opening up about your feelings and experience to your partner or family?	Would you say your mobility was affected? How about your sleep? How did this affect him/her? Would you say it affected your relationship? Tell me more about that
Transitioning and adapting to motherhood	Share with me your views about your transitioning and adapting to motherhood Tell me about feeding and bonding with your baby	How did this affect your care for your new born?
	What kind of post-operative support and care would you have loved to experience if any? What words/terms come to your mind in relation to your overall experience of your caesarean birth? On reflection, how does the experience of your unplanned CS affect your future birth decisions?	Are you generally satisfied with your birth experience?
At the end of each interview	How does talking about your experience make you feel?	Is there anything I haven't asked you that you would like to talk about?

Appendix I: Topic Guide (Care Providers)

Department: Health Sciences
Telephone: +64221220307
Email: charles.egwuba@pg.canterbury.ac.nz
Date:
Supervisor: Dr. Sarah Lovell
Email: sarah.lovell@canterbury.ac.nz

Interview Questions for Health Professionals

Research Question: What are the expectations of birth and the experiences of the maternity health system among women who have had an unplanned caesarean section in New Zealand?

MAIN QUESTIONS	SUB-QUESTIONS
Childbirth and the Maternity System Perspectives	Kindly share with me your background as a midwife/obstetrician practicing in Canterbury
	What is your view about the New Zealand maternity system in relation to childbirth and caesarean section (CS)?
	Have you had women under your care who had complications during labour and needed a CS?
	Is there scope to discuss the possibility of an unplanned/emergency cesarean section with women in your practice?
	How do you approach discussing the birth with your clients who have undergone a CS? As a Midwife LMC, what are the practice implications for you as a midwife when women under your care end up with an emergency CS?
Decision Making Process and Informed Consent	How would you view your role in the decision making process around caesarean delivery for women with birth complications?
	What in your view are the roles of other professionals (midwife/obstetrician) when women consent to have an unplanned CS?
Post-natal Care and Support	What is your view around postoperative support and care for women after an unplanned caesarean birth in terms of wound management, duration and quality of hospital-based support, duration of midwifery support, mental and emotional support?
Midwives Perspectives on Postnatal Care	Are there difficulties caring for a woman who have unplanned CS? Are you adequately supported (e.g. in terms of funding, training and time) to do this work?
Recommendations	Are there changes in postnatal care for women you would like to see after an unplanned or emergency CS?

Appendix J: Framework Matrix of Cases and Codes with Summarised Extracts

Table 4: Experience of care				
	Abrupt shift	Continuity of care	Continuity of carer	Debrief
Dr Uri			After an UEMCS, patients are often not seen by the doctor who did the CS. Women definitely should be seen for follow up, and by the same doctor. This is important for continuity of care [page 5].	Doctors are overworked due to staff strength in the public system, they don't ever get to see the patients after an unplanned CS. Thus, they don't debrief at all. This can also be distressing for the doctors [page 5].
Dr Tim		Continuity of care for women after an UEMCS in the public	Having different carers can be a daunting experience for most	Debrief after discharge is a good practice which should give patients

		system may be limited, as it is majorly reliant on the fact that they (women) have their lead maternity carer, who based on experience, may not be able to convey to the patient why the caesarean section happened [page 5].	women. At times it can make it very difficult for the woman to understand what exactly is going on. This impacts on the general experience of continuity of care, as the woman is seeing a number of different people, each constantly changing [page 1].	the opportunity to be seen by the operating surgeon. The problem is that patients are not often seen by doctors who did the caesarean section, and this is often a source of dissatisfaction both for women and the staff [page 4, 5].
Dr Pam		Women in New Zealand enjoy continuity of care from midwives who spend a considerable amount		Women should get a post-discharge debrief the reality is it's not always possible, which is majorly a

		of time with them at home. This is done properly in comparison to other countries like Australia where women are more likely to receive care from midwives at home only when they've had twins [page 4].		system, facility, practicality, finances and timing issue. Many women definitely fall through the cracks [page 3, 4, 5].
Dr Earl			Women may never see the doctor who did their CS again, it is a potential of the element for "Chinese whispers". It makes a huge difference that when you are in labour the person making the	Women getting a 6 weeks post-discharge debrief from their operating surgeon gives them the chance to actually collect their thoughts and discuss their

			decision is someone you know and have a relationship with [page 3].	experience of the caesarean section, which helps significantly.
Midwife Lib	Predominantly, women plan their birth with a midwife LMC. In the event of an UEMCS, things aren't normal with theatre nurses, extra midwives, obstetric team, and anaesthetic team. It's pretty full-on for women who experience an abrupt shift of care, with their midwives no longer responsible for their birth [page 2]	Having one or few carers who look after a woman from the beginning of pregnancy until 6 weeks afterwards, makes a huge difference	A single carer who knows the woman and who the woman knows, strengthens relationship and enhances shared ideology, which is vital for birth experience [page 1].	Women value the opportunity to go back and see the operating surgeon for a Debrief. Unfortunately, a lot of women don't end up seeing the registrar who did the caesarean section or who made that decision.

Midwife Liz	Midwives feel disappointed when things go wrong with women under their care. The decision for an UEMCS is taken by a registrar or obstetrician. The shift in care management takes all responsibility of birth away from the midwife, which reflects on her own practice [page 4]			Women who present with pre-existing depression, anxiety, or post-traumatic stress link this to previous pregnancy and birth, and report not being de-briefed about their trauma [page 2].
Midwife Mei				Quite bluntly really there isn't any opportunity for women to debrief

				with their surgeon, this can have an impact on women's birth experiences. Women will benefit from a Debrief with the surgeon who performed the operation [page 2].
Midwife Zillah	In the event of an UEMCS, midwives lose their lead carer role because the midwife's role is 'normal' so when it becomes 'abnormal', her role becomes almost obsolete and the midwife no longer have a major role in that. For the			

	midwife, this is disappointing for her practice [page 1, 2].			
Midwife Rose		Women having continuity of care is really awesome because women are assured of their physical care at least [page 2]	Being with a single carer is important for relational continuity of care and has a huge impacts on women's birth experiences [page 2, 3]	A woman who had an UEMCS and understands why, via a Debrief, will feel much more empowered about the process [page 2].
Midwife Kalie		Continuity of care makes the system well set-up for women, which is better than in most places around the world [page 1].		Women should be able to get a Debrief at the right time, when it is significant. Debrief should be offered routinely, not just when it is a life or death scenario [page 3]

Midwife Dona		It has been proven in numerous studies that a continuity of care will give a trust relationship and better birthing outcomes for women [page 1]		Surgeons who perform the caesarean section need to be the ones seeing the women, often the ones below them are sent after the CS, and it is really horrible, sometimes it can be very much like a chop shop [page 4].

Table 5: Nature of care after UEMCS				
	Inadequate	Normalising caesarean section	Mental wellness & support	Improving care
Dr Uri	The unavailability of a PBF in Christchurch (city centre) puts pressure on women living in the city who often have to go to Rangiora or Lincoln for postnatal care, with considerable impact on family dynamics [page 4].		Trauma post-delivery can significantly impact on family dynamics, but there is no mental health service sided with obstetric care for women with traumatic birth experience [page 6]. Midwives do not know how to screen for postnatal depression. A private practice will have	More doctors to reduce the patient load would go a long way to improve care and outcomes for women [page 5].

			psychologists attached, but this is unavailable in the public service [page 6].	
Dr Tim	Inadequate nursing workforce puts a strain on the quality and quantity of care provided to women [page 5]. The LMC model is underfunded, and it cannot	A patient who has had an UEMCS has had a major procedure, with that comes pain and functional issues. When the care offered to those who have had caesarean section and vaginal birth are similar, then that is simply normalising caesarean section [pages 5, 7, 8].	The physical and emotional stresses causes huge changes in the woman's wellbeing and ultimately, may result to depression, but there is very little help, very little help indeed [page 6]	Doctors, nurses and midwives would commonly like more time with their patients given available workforce [page 5]. Need an improvement on the mother and babies unit and the emergency psych team, they're

	take the role of a hospital in the community [page 8].			quite small and poorly resourced [page 7]. Caesarean section rate currently stands between 27-32%. It is important to appreciate this value and give more attention to it in antenatal classes [page 2].
Dr Pam	There is inequality in care and midwife access driven by age, education and socio-economic deprivation [page 1].		Huge group of women have birth trauma from caesarean section, but many don't want to come back to the hospital, it is the site of their trauma [page 5].	PBF postnatal care after an UEMCS that is closer to home will change outcomes for women who live in the city [pages 3, 4].

Dr Earl	Seasonal factors affects midwife's access for many women; if your baby is due at Christmas or over the hols then its difficult [page 1].		A woman with a complicated birth is at high risk of having post-natal depression or anxiety. This may be a reflection of underlining poor mental health and perhaps may be an antenatal care problem, that is, the lack of preparedness and lack of discussions by midwives with women on potential outcomes [page 6].	Our awareness and openness of potential outcomes needs to improve, and the system needs to bring people back for debrief to give closure and foster continuity of care and carer [pages 1, 3, 6].

Midwife Lib	Midwives don't get paid enough, neither are they paid extra for extra hours spent with women who struggle postnatally after an UEMCS, which may affect the amount of care women receive [page 6].		For women who end up with an UEMCS, postnatal depression is really a real issue. Women benefit a lot from postnatal support groups but they cannot reach this groups because their mobility is compromised until after 6 weeks [page 6]	Women need more physical support at home for the first few days, as it is a lot to deal with when it wasn't what you were expecting [pages 4, 5].
Midwife Liz	The service is inadequate to support women who have an UEMCS [page 1]		Often, the link with depression comes afterwards, when stuff like feeding and sleeping are sorted and the woman reflects back on her experience [pages 1, 2]	Women who undergo an UEMCS need more time in the hospital to recover. Four days is hardly enough. They have had a major

				surgery, in an emergency situation [page 5].
Midwife Mei	LMCs number of post-natal care visits are inadequate, which is a funding issue. While some women will fall in between the number of visits, many because of the traumatic birth events or mental illness require more care		The system is failing women in not providing long term mental health support for traumatic births [page 1]	Need to improve postnatal care which gets let down after good antenatal and birth related support Women need more mental health support Midwives need to be more support so they can support women better [page 2, 6].

Midwife Zillah			The process in place for referral requires midwives to send women who are traumatised by their birth experience to the GP, Plunket person or the adjustment programme, however, there is usually a waiting list for 3 months, and GPs are quite restrictive on what they offer which is often unhelpful [page 2].	Counselling services for women by counsellors who are trained in birth trauma will change outcomes [page 3].
Midwife Rose		For every other surgery, the expectation is a follow-up with the surgeon within days, weeks		Need for a new referral service to help women come to terms with the trauma of emergencies in

		and months, but for a mother who has had an emergency caesarean section, she will see her midwife for 4-6weeks, she gets no follow-up visit with the surgeon [page 3]		childbirth. This is imminently important [pages 3, 4].
Midwife Kalie		There are standard expectations around clinical follow-ups after any major surgery. This should be exactly the same for an UEMCS. From a societal and system perspective, women are expected to just get on with it." [page 6]	The biggest gap lies in on-going mental health support for women with post-traumatic birth stressors [page 2]	Need for the funding of a specialised birth trauma counselling service for women who have had a traumatic birth experience [page 6].

Midwife Dona	Follow-up care after an UEMCS is terrible! It comes down to budgeting and finances [page 3].			An integrated care service of midwife and doctors involvement in the care provision for women, before during and after birth will improve women's experiences and birth outcomes [page 4].

Table 6: Maternity system of care

	Woman-centred	Difference in standard	Judgemental	Normal birth absolutism
Dr Uri		Follow-up care after discharge by doctors who performed UEMCS is good care for women. However, public practice do not offer that service at all and do not have the capacity to do that for women either. It is very different in private practice which is the standard you set for care of women [page 5].		

Dr Tim	Women in New Zealand have good outcomes because the system delivers an excellent product [page 1].	The public system does not allow doctors to see their patients after UEMCS, they are to be discharged back to their GP, which is a postnatal care and continuity of care issue [page 2].		Several women are faced with the pressure to breastfeed, but for first time mothers and after an UEMCS, it is a challenging procedure [page 6].
Dr Pam	The system driving continuity of care through a lead maternity carer is good principle which provides good outcomes for babies and their mothers [page 1].	A key principle of the LMC model is women having choice but women don't have a lot of choice currently if they have to fork out 5000 dollars to have an		

		obstetrician for their maternity care [page 1].		
Dr Earl		The system is fragmented and performing poorly if as a public patient you get sent home without debrief or in dollar terms, have a choice of carer [pages 1, 3]. There are very few policies that cover obstetrics and so most people are self-funding [page 4].	The current breastfeeding debate make women feel like they are a failure if they cannot breastfeed [page 2]	The absolute attachment to 'normal birth' and the inability to embrace other options or possibilities, creates room for a religious zealotry about birth [page 2]

Midwife Lib	Compare to a lot of systems out there, New Zealand provides a system that supports continuity of care for women which makes a big difference in their birth experience [page 1].			
Midwife Liz		If the system promotes choice of birth place for women and at the same time say to midwives we can't have any women who are low-risk in the hospital, which is a conflict of standard. It is difficult		The expected gold standard of 'normal birth', and the absolute determination to have normal, is causing a lot of midwives practising dangerously

		to balance supporting choice and having a gold standard of homebirth without any complications [pages 2, 3, 4].		Midwives push and push and push to get a normal delivery, which is whole lot of safety and risk issue and that's because of the midwifery philosophy In midwifery, everything is normal - but it is not; women are becoming increasingly high risk. There's more medically complicated women and the standard normal women no longer exists anymore, or she's very rare [page 2, 3].

Midwife Mei	The way women receive their care is top-notch [page 1].	The funding structure for New Zealand's maternity system benefits women 100% but it doesn't necessarily benefit the carer [page 1].	Women feel judged the way that they birth their baby; whether that be that they had an elective caesarean or they had a vaginal birth, either way there's a lot of judgement from an individual and system level	
Midwife Zillah	The New Zealand maternity system is different from many out there, it can be underappreciated by users but it is a very good and robust maternity system [page 1].			Midwives feel most useless and obsolete when birth becomes 'abnormal' because the midwifery philosophy is normality [page 1].

Midwife Rose	The system provides care on a one-on-one basis which helps women discover their philosophy around childbirth, and meet their birth expectations [page 1].			
Midwife Kalie	The system providing choice for women around their carer and their place of birth is amazing [page 1].	The system is amazing for maternity users but not so much for midwives in New Zealand at the moment [page 1].	there is still some of the attitude that is basically: "you've had a life baby so you should just be thankful" [page 6]	There is so much pressure from the system on women to have a 'normal birth' and breastfeed, which is quite judgemental and breeds a sense of guilt on women for not having a vaginal birth [page 2].

Midwife Dona	The New Zealand maternity system is a system where when it works well it works fantastic! [page 1].			Women are encouraged to birth in a PBF and always informed that choosing to birth in the hospital will increase risk of intervention and caesarean section [page 2].